

# **THE AMERICAN JOURNAL of PSYCHIATRY**

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The management regimen should include:<sup>1</sup>

- I. Good physical and mental hygiene.
  - a) Wholesome diet; Regular bowel habits; Avoid noxious materials, e.g. alcoholics; Moderate physical activity.
  - b) Help overcome feeling that epilepsy is shameful; Encourage normal work and recreation; Regular sleep without overprotection.
- II. Anticonvulsant medication selected on the basis of Exact Diagnosis:

"Certain drugs are more effective in one type of seizure than they are in another, and it is necessary to use proper drugs. The dosage must be individualized for each case."<sup>2</sup>

Thus, the best guide in selecting medication for a patient is the type of seizures present. (Frequently several drugs in combination is most effective.)

The table shows which drugs are indicated for each type

of seizure. It will be noted that the newer hydantoin, Mesantoin, is effective for *grand mal*, Jacksonian and focal seizures.

**MESANTOIN DOSAGE** is adjusted to the lowest level adequate to attain freedom from seizures. Start with 1/2 or 1 tablet daily during the first week; increase the daily intake by 1/2 or 1 tablet during the next week. Continue this up to optimal dosage. When another drug has not given good results, Mesantoin is added by the same procedure; then the old drug is gradually reduced.

**SIDE EFFECTS** — Mesantoin produces side effects in some cases: Skin and blood changes are signs of sensitivity — the drug should be discontinued. Drowsiness develops upon reaching maximum dosage.

**PRECAUTIONS** — Certain precautions are necessary to minimize untoward effects.

- a. close check on patient — repeated visits and blood counts.
- b. No Mesantoin, if white cell count below 4000.
- c. caution if (1) rash or blood changes.  
(2) History of drug sensitivity.
- d. discontinue drug if (1) bleeding of gums or vagina.  
1 (2) Sore throat

| TYPE OF EPILEPSY | PRIMARY CLINICAL MANIFESTATIONS   | MEDICATION                                      | AVERAGE ADULT DAILY DOSE*                             | LIMITING SIDE EFFECTS  | SIGNS OF SENSITIVITY  |
|------------------|---|---|---|--|---|
| GRAND MAL        | Aura followed by loss of consciousness; tonic-clonic convulsions and autonomic disturbance, e.g., in bladder function.                              | Phenobarbital                                   | 1½ grs. h.s. Usual max.: 3 grs. per day               | Sleepiness   |   |
|                  |   | 5,5 diphenyl hydantoin                          | 1½ grs. t.i.d., p.c. Usual max. 6 grs. per day        | Diplopia, staggering (may increase petit mal)  | Overgrowth of gums, body hairs; itching rash on extremities, gastric irritation   |
| JACKSONIAN       | Convulsions begin in one area and spread outwards (Jacksonian march). No loss of consciousness. <sup>3</sup>  | 3 methyl 5,5 phenylethyl hydantoin (mesantoin)  | Adults: 2 to 6 tabs.<br>Children: 1 to 4 tabs.        | Sleepiness   | Full details given, see Psychomotor cross-column below                            |
|                  |   | phenylacetylurea <sup>5</sup>                   | 2 Gms. per day. Max. dose 6 Gms. per day <sup>6</sup> | Drowsiness <sup>5</sup>  | Central nervous system affected, nausea, vomiting and abdominal pain <sup>5</sup> |
| PSYCHOMOTOR      | Period of amnesia; actions apparently purposeful but mechanical; incoordination. Mild tonic spasms. In children: "behavior problems". <sup>3</sup>  | 3 methyl 5,5 phenylethyl hydantoin <sup>4</sup> | Adults: 2-6 tabs.<br>Children: 1-4 tabs.              | Pharyngitis, mucous membrane bleeding, lymphadenopathy, measles-like rash with itching and fever; in severe reaction: blood dyscrasia. |   |
|                  |   | phenylacetylurea <sup>5</sup>                   |   | See phenylacetylurea—above   |   |
| PETIT MAL TRIAD  | Attacks: in series (rapid succession), abrupt onset, few sec. duration; no aura nor impairment of consciousness. Rhythmic switching (e.g. eyelids). | 3,5,5 trimethyl oxazolidine 2,4 dione           | 0.9 to 1.2 Gms.                                       | Inability to see in a bright light. Drowsiness   | Hiccough, acneform rash, leukopenia   |
|                  |   | N methyl derivative of phenobarbital            | 6 grs.  | Sleepiness   |   |

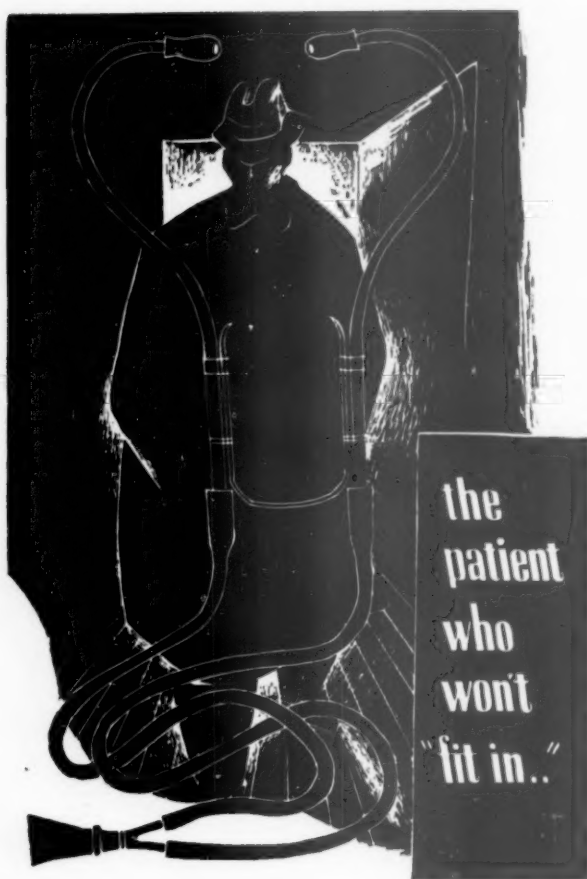
\*Although an average daily dose can be stated for each of these drugs, to obtain best results it is necessary that the physician determine the dose required by each individual patient for maximum control of his seizures.

Bibliography: 1. Carter, S., in Conn, H. Current Therapy 1949. Phila. Saunders Co., p. 495. 2. Kaufman, I. Dis. Nerv. System 11: 99, 1950. 3. Lennox W. Science & Seizures, ed. 2. N.Y.C., Harper & Bros., 1946. 4. Harris, T. & Otto, J. Texas J. Med. 43: 528, 1947. 5. Little S. & McBryde, R. Am. J. M. Sc. 219: 494, 1950 (Except as otherwise indicated, the data tabulated is from: Gibbs, F. Ann. Int. Med. 27: 548, 1947.)

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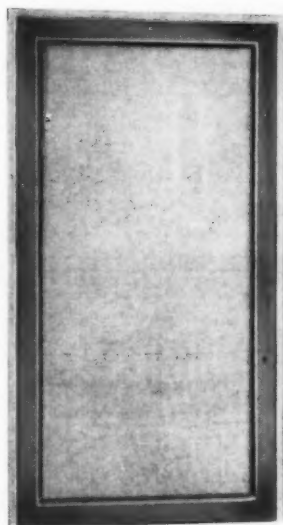
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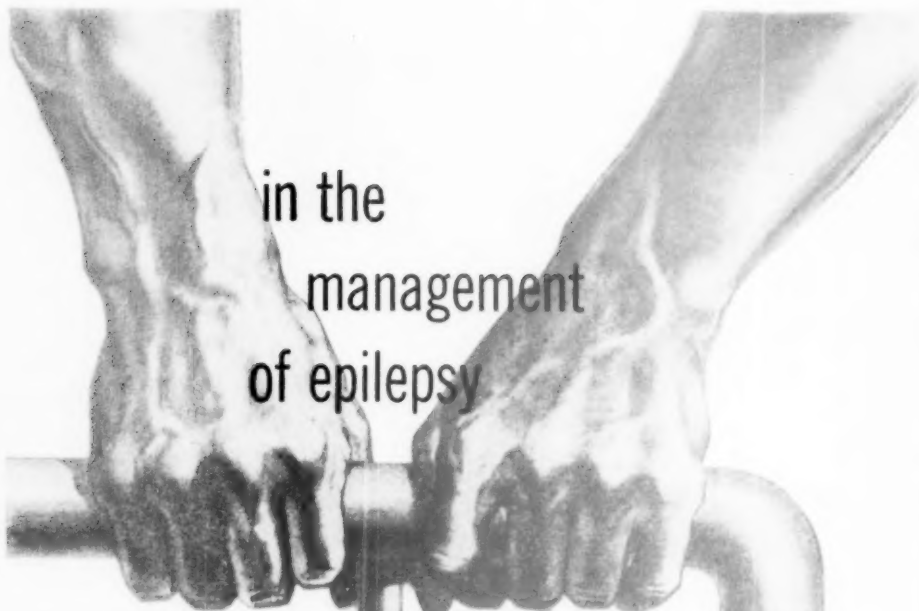
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<sup>\*</sup>Cutting, W. C.: A Manual of Clinical Therapeutics, ed. 2, Philadelphia, W. B. Saunders & Co., 1948, p. 481.

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SOME REFLECTIONS ON THE DEVELOPMENT OF PSYCHIATRY  
IN GERMANY

PROFESSOR DR. ROBERT GAUPP, STUTTGART-DEGERLOCH

Looking back today we may say that German psychiatry had reached its high point at the turn of the last century. It is, after all, still a young science, and Wilhelm Griesinger may be considered its father.<sup>1</sup> The second half of the 19th century saw the triumphal progress of medicine based on exact natural-scientific research. This became extremely important for psychiatry, a science that had, in the years before, frequently been led to erroneous conclusions under the influence of natural philosophy and moral theology. It was Griesinger who declared that mental diseases are diseases of the brain, an opinion that we meet even in antiquity, in Hippocrates. Anatomy, physiology, and pathology of the brain advanced enormously along scientific-materialistic lines during the second half of the 19th century. Like the other provinces of medical research, psychiatry was also firmly based on the principles of biological thought and investigation. Consciousness of the great progress that had been achieved was often the cause of insufficient recognition of the limits of psychiatric knowledge. Therefore I thought it necessary to point out, 50 years ago, in an epistemological paper, the essential differences between organic occurrences in the brain and psychic relations.

About the turn of the century two scientists in Germany, Karl Wernicke and Emil Kraepelin, determined, as a result of their lifelong research work, modern psychiatric science. They were very different in their ways of thinking and also in their methods of research. As I worked with both of them for several years, I can speak from personal recollection. Wernicke in Breslau was, in the first place, a brain pathologist, and tried to further psychiatric science by the investigation methods of brain pathology and, in this way, to assimilate psychiatry to the other

fields of medicine. As a brain specialist he contributed conclusive evidence of the localization of psychic processes in certain regions of the cerebrum. All his life he had been convinced that the epoch-making progress of brain pathology would be of equal benefit to psychiatry. We know now that this was an epistemological error. Nevertheless, Wernicke's work has been extremely important, especially because of the exceptionally meticulous methods of physical and mental examination of sick people that he made use of.

The approach of Kraepelin toward these problems was fundamentally different. As a pupil of the great philosopher and psychologist Wilhelm Wundt he was, in principle, inclined to approach the analysis of the sick psyche by psychological means. As a clinical investigator of indefatigable and extreme persistence he had set himself the task to obtain, purely on the basis of experience, a complete survey, as far as possible of all the forms and courses of mental disturbances. He studied each single case that he had dealt with in his long lifetime's research, with every examination method both physical and psychological. He wanted to know everything that "occurs" in the realm of psychiatry, then to group the gathered material, and so in place of symptoms and symptom complexes to establish true disease entities. He had outstanding collaborators, particularly in Alzheimer and Nissl, who laboriously and with the utmost precision investigated the anatomical and histopathological changes in the various mental diseases in the effort to differentiate them with accuracy. The investigation methods of chemistry were also utilized as far as it was at that time possible. The controversy over the "disease entity" as the most important problem for the clinical investigator still dominated the first two decades of the 20th century. Kraepelin was much attacked and many believed his ideal of research utopian. Time and again one

<sup>1</sup> Griesinger's *Die Pathologie und Therapie der psychischen Krankheiten*, published in 1845, is looked upon as the first modern textbook of psychiatry.

was confronted with cases that did not fit into any classification, and that proved any prognosis futile. Nevertheless, the main result—the formulation of large groups of mental diseases with definite causes, definite symptoms, and a definite course—was established and stood the test during the following decades. The discrimination between the constitutional origin of a mental disturbance and that conditioned by external, injurious factors, became much more precise. Two large groups emerged more clearly: the schizophrenic illnesses and the manic-depressive psychoses. These two groups have constituted the basis of our systematics, even to the present day. In addition there were the so-called organic psychoses (general paresis, senile psychoses, deficiency diseases based on vascular or toxic disturbances); also the congenital defective conditions and the large field of psychopaths. The transition from a neurosis to a psychosis became clear and comprehensible through the influence of modern, deeper penetrating psychology.

Jaspers created the invaluable discrimination between causal and comprehensible relations, putting in each case the cardinal question: whether a given pathological condition represented the progressive development of an abnormal predisposition or the effect of an intercurrent disease process.

I, personally, deviated from this view, since experience had taught me that mental disorders were very different as to frequency and clinical picture in the various parts of the world, and also in the different towns of Germany. I became increasingly convinced that the infinite variety of the clinical pictures did not depend so much on the difference of the disease processes as on the difference of the personalities who were mentally afflicted. I was greatly concerned to uncover all the threads leading from the sane personality into the phase of his or her illness. During the 30 years that I was director of the Psychiatric Clinic in Tuebingen, my pupils worked with me on the problem of clarifying the interaction of personality and psychosis. I realized that we can obtain a deeper knowledge only if we are able to analyze exactly each individual case with regard to heredity, predisposition, and external causes. I sought therefore by

studying for many years the case of a paranoiac, the school teacher and mass murderer Wagner, to demonstrate the relations existing between his character, his temperament, external influences, and the development of his mind. I was in a position to survey clearly the entire course of his disease, aided by the numerous diaries of the highly intelligent patient, and by my own observations, extending over several decades until his death. Above all, I could thus contribute to a clarification of the question: what had been predisposition and what destiny?

In his book on "Sensitive Paranoia" Kretschmer further developed these ideas; and the time had now come when, under the influence of Karl Jaspers' acute observations, more light was being shed on the problem: how does a given personality become insane under the pressure of physical illness and emotional experiences; and what factors determine the course of his illness? During our investigations at the Tuebingen Clinic Kretschmer again took up the new line by studying the physique and character of man, in order to obtain a clear picture of the personality before the incidence of mental affliction, which would offer an explanation for the variety of the clinical pictures.

The investigations of Freud, which reach back to the last decade of the 19th century, and also the work of his pupils created the system of psychoanalysis as a special method to obtain insight into the deeper, hidden forces of the mind, and to show that much that had seemed incomprehensible before becomes significant and meaningful by revealing all the life relationships. The psychoanalytic method, which contributed much that was new, particularly in the field of nervous conditions; has met with an enthusiastic reception, as I well know, especially among Anglo-American psychiatrists. It even seems to me as if the joy in this new knowledge would cast all other research into the shade. There is a danger that the psychiatric discipline might disintegrate into psychological-psychoanalytical procedures, leading to an underestimation of the great complexity of all the manifestations of mental abnormality.

Careful contemporary investigation on heredity factors has produced many impor-



tant findings, to mention only the research on twins, which teaches us unambiguously to what high degree the destiny of man is determined by his inherited and inherent disposition. I would call attention to the book by Johannes Lange, "Crime as Destiny." We learn from it that the inborn disposition is of the utmost importance, and also that the experiences of early childhood do not exclusively determine the later destiny of a human being. In the last decades we have also learned that the unaccountable clinical pictures, which defy any classification, can be naturally explained by a crossing of hereditary influences of various types, which result in a mixture of healthy and morbid traits, making an analysis very difficult. We have two parents, four grandparents, and eight great-grandparents who, all of them, are of incisive influence on the growth of our own personality. Years ago, in collaboration with Mauz, I insistently called attention to the "mixed psychoses" resulting from these relations of inheritance.

The last decades, particularly our experiences during the two world wars, have essentially elucidated one special field: hysteria. The Berlin psychiatrist Karl Bonhoeffer (d. 1948) gave the ambiguous concept of hysteria a more clearly defined meaning when he demonstrated the morbid direction of the will (*die krankhafte Willensrichtung*) as the essential cause of the hysteric symptom. The results of his investigation are perfectly consistent with the findings of psychoanalysis and I consider it a great gain that the term "hysterical" is no longer used in the vague and often morally disparaging sense as was the case for many years. In this field we owe a great deal to the research of the French, mainly to Charcot and Janet. During the world wars we saw, from innumerable experiences, that a definite direction of the will represented the driving force of all the manifold symptoms of hysteria.

The fundamentally pessimistic mood of our times (particularly deep-felt in Germany) has time and again raised the question of whether we are facing—not only in

our own country but in mankind in general—definite indications of a "degeneration of the civilized peoples." Spengler wrote about the Decline of the West; modern existentialism emphasizes the feeling of uncertainty and futility in our present intellectual world. Some talk about a "proletarianization of a people" as the result of lesser reproductive capacity among "high quality" people compared to "poor quality" people. Some believe that the time is ripe to take practical measures to bring about a regeneration of the civilized peoples of our times; the propagation of "poor quality" people should be prevented. This movement, which originated as you know in North America, had taken firm roots also in Europe; and Hitler's Germany had thought itself justified in sterilizing those who were hereditarily tainted and of "poor quality," or even exterminating them with brutal force. That grave aberration has been overcome today. What still exists, however, is the serious problem of an ever-increasing overpopulation, due to prolongation of the life span, and to the diminished danger of epidemics. But there is still the awareness that the number of "poor quality" increases more rapidly than the number of "high quality" members of a people. Respect for life, however, forbids us to intervene by public measures. We are aware that we must attempt to counteract the danger of "proletarianization" and the lowering of standards by enlightenment and education. The problem of birth control will not disappear again. In spite of all the technical progress in the field of destruction of human life by means of force (wars) the danger of an overpopulation of the earth is threatening us, above all the occidental peoples. The native impulses are too powerful to assure that rational considerations may exercise control. No other way will be left but "rationalization of propagation." Here the experiences of genetics and clinical psychiatry should have a voice. The future of mankind will be essentially decided by the correct solution of this problem.

## ROBERT GAUPP

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About a year ago Professor Robert Gaupp, a great figure in European, and particularly in German, psychiatry, celebrated his eightieth birthday. Although he is no longer active in academic life and lives, retired, in Stuttgart (South Germany), he maintains the keenest interest in the problems of psychiatry and is in constant touch with other psychiatrists, especially with his many old pupils.

His eightieth birthday found Professor Gaupp in Heidelberg, where exactly a half century earlier he had begun his academic career. Here at the request of the present head of the department of psychiatry, Professor Kurt Schneider, he gave an impromptu address in which he reviewed those 50 momentous years of German psychiatry, and in particular the part played by the Heidelberg Clinic in the dramatic story. Unfortunately no record was made of this totally unprepared but memorable address, and it could not therefore find its way into print.

Gaupp comes from an old Swabian family. Becoming early interested in neurology and psychiatry, he served first in Breslau under Wernicke, and was then attracted by the work of Kraepelin, who was pioneering in research on the problem of classification and experimental psychology in Heidelberg. Gaupp joined him there and went later with him to Munich.

He left Kraepelin in 1906 to assume the position of Director of the Psychiatric Clinic in Tuebingen, a position he held for 30 years. In 1917 he was invited to take the chair in psychiatry in Heidelberg but could not persuade himself to leave the university of his homeland and remained in Tuebingen. His first paper from that clinic was on "Ways and Aims of Psychiatric Research." Under his direction Tuebingen became a famous psychiatric research center. As it was the only university in Swabia, Gaupp had the unique opportunity of seeing and observing nearly all the mental cases occurring among the Swabian population, since all psychotic patients had to pass his clinic before being

sent to a state hospital. With great thoroughness he studied the extremely gifted, peculiar, speculative Swabians, among whom, more than in other parts of Germany, all sorts of mild and severe manic-depressive psychoses could be found.

Gaupp was interested not only in clinical psychiatry but also in the borderline provinces, and he was one of the first psychiatrists interested in pastoral psychology and psychiatry. He was also much concerned with general problems, *e.g.*, the physician as an educator, and the causes of increasing nervous disturbances. He spent a great deal of his time thinking and writing about "Student and Alcohol"; and his mind was forever occupied with the whole problem of alcoholism. But all this was at the periphery of his central idea: to create a research centre with many good co-workers who, under his guidance, would collaborate toward one goal, namely, the investigation of the relationship between personality and psychosis. This was at that time a new field of research, in which Kraepelin had become interested only at the end of his life. Gaupp was fortunate in finding a great many clinical psychiatrists who were eager to work with him. It was in his clinic that Eduard Reiss published (in 1910) his important study on "Constitutional Depression and Manic-Depressive Psychosis," based on his clinical investigations of predisposition and psychosis. It was at the same time an extremely informative study of the Swabian population, theoretically influenced mostly by Gaupp and perhaps also by an almost forgotten but important paper by Tilling, published 1904, on "Individual Character and Psychosis."

Another of Gaupp's pupils, Kretschmer, published his book "Physique and Character" and later his clinical study on sensitive paranoid reactions while he worked at the Tuebingen Clinic; and these two books were followed by many other papers by other authors dealing with the same problems. In those years K. Brodman followed up in Tue-

bingen his studies on cytoarchitectonics, and Storch wrote his "Autistic Thinking of Schizophrenics." Storch, together with another of Gaupp's pupils, Heidenheim, published also very interesting pathobiographies, based on Gaupp's concept of personality and psychoses. There were many others in the group—to mention only Otto Kant and his work on clinical psychiatry. The methods of investigation at the Tuebingen Clinic under Gaupp can be compared only to those of a similar clinical team working at the Heidelberg clinic where, under the direction of Wilmanns, a group of research men with a diversity of approach formed a unique unit.

Gaupp's ideas on personality and psychosis reached a high point when, in 1914, he published his criminal-psychological-psychiatric study on a keenly observed and excellently described case of paranoia: the case of the teacher and mass murderer Wagner. This book, which is unfortunately not too well known in Anglo-American countries, is one of the profoundest studies on the psychology of paranoia and on the relation between personality and psychosis. Gaupp had been fortunate in being able to observe Wagner during a long period until the patient's death. He published in 1920 a second paper on Wagner, and continued writing about the

development of this psychotic disturbance.

It was in Gaupp's clinic that Kurt Schneider worked for years and published some of his papers. Reiss, Kretschmer, and Schneider later left for leading positions as psychiatrists at other universities.

Gaupp went on investigating and writing until his retirement in 1936. Even afterwards he developed new ideas. He was always in close contact with Bonhoeffer, whose death was a great shock to him. When I visited my old teacher, Professor Gaupp, some months ago and saw him again after 20 years, I was astonished at his youthful energy. He showed a lively interest in the present state of psychiatry in all countries, although he was skeptical about many developments; and he was still busy recording his thoughts and impressions on the development of European psychiatry. Although doubtful about the way American psychiatry had come under the sway of psychoanalytical theories, he was not, like many other European psychiatrists, absolutely hostile toward analysis, and recognized its contribution to a better understanding of the neurotic mind. But he was also aware that the orthodox approach to analysis might obscure all the other efforts that are continually being put forth in the investigation of the sick mind.

## THE ROLE OF INSIGHT IN PSYCHOTHERAPY<sup>1</sup>

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Our hindsight is proverbially better than our foresight, but our insight is no doubt worse than either. Certainly this is true if by "insight" we mean insight into ourselves. For here we are notoriously blind. But does a lack of insight cause symptoms and various failures in adjustment, as many psychiatrists seem to suppose, and does increased insight tend to bring about recovery? What, in fact, is the role of insight in psychotherapy?

In raising questions about the role of insight in psychotherapy, let us be sure that they are real questions, and not what Carnap calls pseudoquestions—a pseudoquestion being one that, although it has the syntactical form of a question, is not even in principle answerable. If the question is genuinely significant, we shall be able to picture to ourselves the state of affairs, the occurrence or nonoccurrence of which would answer the question, affirmatively or negatively. More precisely, a question has factual meaning, and is scientifically answerable, when we understand it in the sense that we *could* recognize that pattern of data that, if given in perception as a consequence of such-and-such operations, would at least partially determine the truth-value of an answer to the question. Applying this methodological principle to our question about insight, it implies that our first task, before either affirming or denying anything about the role of insight in psychotherapy, is to clear up the meaning of insight to the point where we can see that our questions about it are operationally significant.

First, then, there is the problem of definition. While such cognitive processes as perceiving, identifying, and remembering are necessary psychological conditions of insight, they are not sufficient. Insight is based upon

and utilizes these simpler mental processes, but it adds something more or, rather, it relates and organizes the contents and products of such cognitive activities so that some heretofore ungrasped meaning, some new but relevant and significant relationship is, perhaps for the first time, clearly understood.

Insight may be into any one of four kinds of relations, or into any combination of these relations. These relations may, for convenience of reference, be labeled as follows:

- (1) Symbol → Referent.
- (2) Sign → Significate.
- (3) Means → End.
- (4) Cause → Effect.

There are, to be sure, many other kinds of relations that are important for logic, mathematics, and science, but for our purposes these four types are perhaps most central and fundamental. A few definitions are probably in order.

(1) *Symbol*.—Any recognizable item of experience that, by virtue of convention, refers to some other (at least possible) item of experience, which is called its "referent." A symbol is optional, is socially instituted, and is rule-governed. Furthermore, a symbol may be meaningful, even though no referent for it exists, or in other words, even though the class it symbolizes is empty. Examples are ordinary words, chemical formulas, mathematical signs.

(2) *Sign*.—Any recognizable item of experience that, by virtue of experience but not convention, signifies and functions as evidence for the existence of some other item of experience, which is called its "significate." A sign is not optional, is not socially instituted, but is empirically discovered, and is not governed by any rule although the sign-significate relation implied may be described by some law. Examples are clouds, blushes, and rales.

While both of these definitions are couched in terms of experience, it should be recognized that either a symbol or a sign may

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refer to or signify either hypothetical constructs or inferred entities, which latter may not be directly experienceable through acts of perception or introspection. Examples are electrons, unconscious ideas, and divine beings.

(3) *Means*.—Some instrument (word, gesture, drug, scalpel) that can be suitably manipulated and is in certain essential respects under our voluntary control, so that—assuming standing conditions are fulfilled—it functions as a sufficient condition of bringing about some consequence that, in relation to the means, is an end-in-view.

(4) *Cause*.—Some antecedent empirical factor that, being given or occurring, results in some other distinguishable event called its effect. More rigorously, if we let A stand for the cause and B the effect, then the cause-effect relation holds—assuming standing conditions are fulfilled—when the following relations hold:

- (a) If A, then B.
- (b) If not A, then not B.
- (c) If A varies, then B varies.

When we stop and consider the kinds of thought processes in our patients to which we give the name of insight, we believe that, in most instances, the insight will be into a sign-significate or a cause-effect relation, although more or less indirectly symbol-referent and means-end relations are probably always involved. This is true because a large part of the patient's material is verbal, i.e., consists of symbols, and because the patient, both intentionally and unwittingly, is trying by both verbal and nonverbal means to attain various ends, including attempts to influence the thoughts, attitudes, and overt behaviors of the therapist.

As for the therapist, he is constantly making inferences from natural signs presented by the patient (for example, blockings in speech, changes in skin color, symptomatic acts, observed signs of tension or relaxation, peculiarities of gait or posture) to various significates, such as conscious anxiety, repressed hostility, displaced oral derivatives of an unconscious sexual impulse, and so on. In some of these cases the significate is also a cause or partial cause of the natural sign in question, with the result that most of the

doctor's thinking, whether about diagnosis, etiology, prognosis, or therapy, consists of inferences or truth-claims regarding sign-significate and cause-effect relations.

It is sometimes said that insight occurs suddenly, that it comes in illuminating flashes, with some area of darkness instantly dispelled, or that it comes in resolving inferences, with some perhaps long-standing problem quickly solved. But we also, and perhaps with equal truth psychologically, may speak of the slow growth of insight, with the suggestion that much of this growth process, this clarifying and organizing of our ideas, goes on underground in at least the comparative darkness of our preconscious mind. Such a slow growth and development in understanding, once the narcissistic crust of top soil has been softened by the gentle rain of mercy and love, may suddenly break through and flower into insight. Time, then, is not of its essence, and whether insight comes quickly or slowly, easily or laboriously, does not either make it or keep it from being insight.

While we tend to think of insight as an outstanding moment in experience, as a kind of intellectual consummation when the parts of some puzzle fall into place, or some badly tangled knot is finally untied, it is obvious upon reflection that no sharp distinction can be justifiably made between these problem-solving, tension-reducing processes and their simpler cognitive precursors and components, such as noting, recognizing, expecting, recalling, inferring, and so on. To argue over the precise point in the development of our thought-processes at which insight begins is about as futile as to argue over the exact instant when consciousness begins in the process of waking up or the split second when night really falls. Much breath has been wasted on such futile questions, in which we vainly try to stipulate conceptual distinctions that cannot, in the face of the relevant data, be either perceptually discriminated or operationally tested.

So far we have been talking about what might be called "generic insight," i. e., about the logical conditions that must be fulfilled to make any cognitive process a case of insight. In a few words, then, our definition of generic insight is any cognitive act by



which we grasp the significance of some pattern of relations. The act is called "cognitive" because insight is a problem-solving, knowledge-yielding process, as contrasted with conative impulses to action or affective states of mind, which do not, *as such*, express inferences, make truth-claims, or yield knowledge.

But psychiatrists, generally, have not been particularly concerned with the distinctive features of generic insight. Their concern has mainly been with what is sometimes called "emotional insight" and with something that we shall call "dynamic insight." Now before this semantic fog closes around us, let us see if we can quickly get our bearings.

Perhaps the best way to try to clear up some of the issues here is to analyze briefly a clinical case. If a patient reports that he has noticed that whenever he quarrels with his wife during dinner he later suffers from indigestion, does this patient have insight? Obviously the patient has noted and we may assume has correctly labeled two sets of events, (1) quarreling with his wife, and (2) suffering from indigestion. Ordinarily, if a reasonably intelligent and well-informed patient reported this sequence of events, he would probably be inclined, at least tentatively, to make the vague inference that the quarrel had "something to do with" the later indigestion. Ordinarily but not of course necessarily. If a quarrel with his wife fills the patient with intense anxiety, if he defends himself against such ego threats by repressing all ideas connected in his mind with their apparent source, he may report indigestion on various occasions without even remembering the antecedent quarrels with his wife. If so, then filling in these anamnestic gaps would be the first step in the patient's gaining any kind of insight, memory in general furnishing some of the necessary material. Or the patient may possibly remember both the quarrels and the subsequent indigestion, but fail to connect the two, except indeed in some indirect way by expressing, as contrasted with describing, the connection through the medium of his associations. But, as we all know, such expressions may be unconscious, as far as the patient is concerned, and hence while they

may stimulate insight in the therapist they do not report its occurrence in the patient.

Any definitional choice we may make here is certainly optional and may be called arbitrary by critics who believe the line should be drawn somewhere else. But if our patient remembers both the quarrels and the indigestion and infers that the indigestion was probably caused, at least in part, by the quarrels, we should honor this degree of pertinent understanding by saying that the patient had at least some insight. Why? Because the patient, by hypothesis, has grasped the significance of some pattern of relations. He may or may not stop quarreling with his wife, and his indigestion may or may not be relieved, being in fact due largely to any one or combination of a hundred "organic" factors. But still the patient has exhibited the sort of behavior that seems to conform to our definition.

However, before we can validly say this, one troublesome ambiguity must be cleared up. Is it really "insight" if the causal hypothesis that (say) *without* the antecedent quarrels he would not, on such and such occasions, have suffered from indigestion, is it really "insight" if this hypothesis is disverified, i.e., proved to be false? In other words, is insight, by definition, necessarily true, or may we have false insight? Notice that, if insight is thought of as analogous to judgment, then insight, like judgment, might be either true or false, sound or unsound, rational or irrational. The relevant facts here are obscure, and linguistic habits here as elsewhere no doubt vary capriciously, but we think the semantic tendency is to restrict the term "insight" to cases where the truth-claim expressed *would be* verified, if the necessary and sufficient verificatory operations could be carried out. This definitional rule, if adopted, would exclude cases of false insight. Hence, strictly speaking, our unhappily married patient does not really have insight if his belief that the quarrels not only led to but also partly caused his attacks of indigestion, is unsound, i.e., if the causal hypothesis in question is false. One logical consequence of this definitional restriction is that, in the vast majority of cases, neither the patient nor the therapist is in a position to know for certain whether real insight has been gained; for in



psychiatry, if many truth-claims are made, few indeed are, or perhaps can be, fully verified.

However, let us assume that the causal hypothesis of our patient regarding the psychogenesis of his indigestion is true. In this case, then, he does have insight. But most psychiatrists and surely all psychoanalysts would feel that this kind of insight is pretty superficial and hardly does more than scratch the surface of what are probably the patient's real problems. In this attitude we concur. Since the clinical objective of the psychotherapist is to cure the patient, or at all events to make him more comfortable and to help him to live more efficiently and happily, this therapeutic goal, along with relevant past experience, suggests the need to go deeper into the patient's problems. This highly gratifying term "deeper" ordinarily means, in practice, going further back into the patient's history and digging up early pathogenic material, and since this material (by definition in analytic theory) is more or less deeply repressed, the further we go back in time the deeper we have to dig, in what is hopefully felt to be the direction of some nuclear complex, now long since hidden in the darkest recesses of the patient's unconscious. With these assumptions and hopes we also largely concur.

Why? Because we believe that clinical experience indicates that the patient's merely inferring, however validly, that quarreling with his wife causes indigestion, will not generally bring about a reduction of his symptoms, will not enable him to stop quarreling with her nor to avoid the alleged consequences. Nor is it likely to bring about other desirable changes in the patient's behavior and personality, such as, for example, making him less irascible toward other persons he has to live with or work with, or making him less morbidly sensitive to expressions of hostility from his wife and others or making him less dependent emotionally, for some necessary modicum of self-esteem, on what his wife and others say to him or do for him.

Hence, the dim view that psychiatrists generally take of what is sometimes called intellectual insight. But as we have seen, any insight is intellectual, or better cognitive; in

fact it must (by definition) be this or it would not be insight. But clinical experience, as well as everyday observation, shows that much so-called intellectual insight consists merely of plausible sounding patterns of words, and words unfortunately are cheap, particularly in the mouths of narcissistic patients where they regularly undergo defensive devaluation—wise men's counters, as Hobbes said, becoming the money of fools. Such patients with their too-ready intellectual patter, dressed up in the latest fashionable jargon, rush headlong into speech, as if to beat the analyst to the punch and to show him that they can, without turning a hair or skipping a heart beat, face "the worst" about themselves. Such pseudo-insight, springing from counterphobic impulses, will not deceive any experienced psychotherapist.

But even where—as in our patient we assume—the words are connected with clearly grasped and honestly accepted ideas, still the case may not move. This stubborn immobility on the part of the patient may, to be sure, sorely conflict with the therapist's own residual delusions of omnipotence. But whatever his unconscious motives, the therapist may, on objective logical grounds, legitimately begin to wonder whether the patient has felt vividly enough the connection between (say) the personal stimulus and his own prior emotional response, or whether the patient has sufficiently relived or adequately abreacted some earlier traumatic experience. From such impressions, the therapist is likely to infer that one trouble is that the patient has intellectual but not emotional insight.

While not disagreeing essentially with what is evidently meant by the term "intellectual insight," we feel that, since any insight by definition is intellectual or, as we prefer to say, cognitive, it is less misleading to call the sort of insight in question "neutral." By this we mean to imply that neither of the terms in the relation whose significance is grasped by the act of insight is an emotion, nor does the act of insight mediate or release at the time an emotional response in the person who has the insight.

With this definition in mind, let us ask ourselves if our patient has emotional, or only neutral, insight? He has, we have as-

sumed, causally related his quarrels with his wife to his attacks of indigestion. Now let us further assume that he believes that the reason the quarrels caused his indigestion is that he became, during the course of them, very upset emotionally: that it was therefore not merely the overt acts, verbal and otherwise, of his wife, nor his own in retaliation, that caused the indigestion, but the resulting inner emotional state, with its whole set of autonomically mediated somatic responses, that caused the gastric dysfunction and gave rise to the signs and symptoms he interprets as his indigestion. Now we do not mean to imply that our patient's favorite reading matter is Weiss and English, Wolf and Wolff, or the journal of *Psychosomatic Medicine*. Obviously his technical understanding may vary within wide limits, but the question is, if he does have insight into the causal role of his anxiety and hostility in bringing about the indigestion, whether this constitutes emotional insight. Notice that in this case the insight is into a causal relation, one term of which is an emotion, or a set of emotions, the other term here, the effect, being the indigestion. Needless to say, the patient may not respond emotionally to hypothesis about the causal role of his emotions in producing his symptoms, any more than some Don Juan, recounting on the couch in lurid terms his various sexual exploits, is necessarily going to relive them emotionally and so become, then and there, sexually excited. After all, sane people do not—except in certain relevant respects—respond to symbols in the same way they do to their referents.

We repeat our question. Does our patient, who merely understands the role of his emotions in producing his symptoms, have emotional insight? In the sense indicated, yes; that is to say, he interprets his symptoms as being partly due to his emotions, his emotions in this relation being a part of the complex referent of the descriptive symbols constituting the causal interpretation in question. In this kind of emotional insight, the emotion is a part of the subject-matter into which the patient has insight, or, more precisely, it is a term in the relation whose significance is grasped through insight.

But another sort of relation, which is of-

ten confused with the kind just explained, may be instituted between the patient's insight and his emotions. Our patient, for example, might through analysis become aware of his extremely dependent attitude toward his wife and of his compulsive, insatiable need for constant reassurances of her love, and this insight might release a flood of emotions in the patient. In such a case, the insight, while expressing a hypothesis about his emotions, also cognitively mediates an emotional response in himself at the time. In other words, when insight is in this sense emotional, it makes the patient conscious of a fact, which itself may or may not be an emotion, that *releases* or *sets off* an emotional response.

These two different relations between insight and emotion are, we think, important to distinguish. Whether each of these relations makes the insight emotional is a matter requiring definitional choice, since obviously the facts themselves, however important, do not force upon us a particular answer to this question of definition. Our choice is to call them both forms of emotional insight and to make clear in the given context *which* of the relations implied holds.

This leaves for brief discussion the important problem of "dynamic insight." The importance of this problem is clearly brought out by Kubie's statement: "Insight begins to have therapeutic effect only when it leads to an appreciation of the relationship between buried experiences and the unconscious conflicts, out of which arise both the neurotic components of the personality and the neurotic symptoms themselves."<sup>4</sup> The word "only" in this sentence might be a little hard to justify, since it implies that, for example, if our patient with the indigestion had not buried—which means, in the context, we take it, repressed—his traumatic experiences in quarreling with his wife, then no therapeutic benefit would follow from his emotional insight into the causal role of the quarrels in producing his indigestion. But is this *known* to be true? May not perceiving a sequential, and inferring a causal, pattern, even if the antecedent factor has not previ-

<sup>4</sup> Kubie, L. S. *Practical and Therapeutic Aspects of Psychoanalysis*, p. 34. New York, International Universities Press, 1950.

ously been forcibly buried in the unconscious, lead to better understanding of the determinants of our choices and the genesis of our symptoms, and may not this insight, although not deep in the Freudian sense, release some emotion and so alter energy relations within the personality that some "therapeutic effect" may result as a consequence of the insight? We shall leave the matter in the form of this question—which, in any event, is probably where the evidence leaves it.

However, before trying to evaluate the therapeutic effects of what we shall call "dynamic insight," let us be sure that we are clear as to the meaning of this expression. Using again our patient with the indigestion for purposes of illustration, if—as we suggested above—he found out, through analysis, that he was neurotically dependent upon certain forms of emotional reassurance from his wife, with the result (say) that he demanded, on pain of violent explosions of hostility, certain oral forms of sexual gratification from her, and if this attitude was traced back to certain repressed Oedipal material, and if, finally, our patient gained insight into the causal role of this repressed material and his frequent quarrels at dinner with his wife, then—according to the definition we propose to recommend, although obviously we did not invent it—our patient would have achieved that intellectual *summa bonum* of analysis, i.e., dynamic insight. Such insight is "dynamic" in the systematic Freudian sense of penetrating the repressive barrier and making the ego aware of certain hypercathected wishes that were previously unconscious. In terms of our logical scheme of relations, such dynamic insight is into a set of sign-significate and cause-effect relations, in which some of the terms, i.e., the significate and the cause, are unconscious, in the dynamic sense of this word that implies repressed. In short, as here defined, there would be no dynamic insight, if there were no Freudian unconscious; whereas, by contrast with this logical consequence, the Freudian unconscious might be a myth, and this would not affect in the slightest the possibility of either neutral or emotional insight, whatever other unforeseeable consequences might follow upon

such a universal withdrawal of ego-anticathexes.

How dynamic insight produces therapeutic effects is of course a difficult question to answer. But presumably it does so through the "economic" shifts brought about with their consequent alterations in the unconscious cathexes on "thought-contents" at various levels of organization in the symbolic behavior of the patient. As a result of this unconscious revolution, various forms of energy may be released and become available for the constructive purposes of the no longer id-enslaved ego, which is therefore better able to make choices that are not blind or compulsive but in the light of relevant facts and values.

Of the three kinds of insight we have distinguished, neutral, emotional, and dynamic, the last—for those with enough "ego-strength" to stand it—no doubt produces the most extensive changes in the character structure of the patient and probably brings about the most lasting therapeutic benefits. But it is naive to assume that even dynamic insight is always a good thing, and that the more of it the better. In most cases of psychoneuroses, because of its problem-solving and tension-reducing effects, insight does tend to relieve symptoms and to yield some satisfaction. To feel that one is catching on to and getting a hold of oneself is undoubtedly an anxiety-relieving, self-esteem-building, ego-syntonic experience. But such beneficent effects are, alas, not inevitable. One is reminded of the old lady who reported to her psychiatrist that she had been facing facts all her life, but that she still couldn't stand the sight of them! Certainly in some cases, particularly older patients with more liabilities than assets, insight (if achieved at all) may well do more harm than good—insight being added to injury. No one is likely to feel happier as a result of contemplating, however clear-sightedly and realistically, inescapable facts about himself that are deeply repugnant to his self-esteem. Unless self-knowledge does give us the power to change, if not the past, then at least our emotional attitudes toward it and the future that grows out of it, so that we can face our lives not only with clearer understanding but also with less guilt and more courage

—unless insight does this, which is asking a great deal of it, it may be only another sad variation on the theme of failure. In the latter case, the wise psychiatrist will administer anodynes to deaden suffering, not butt the head of his patient against a stone wall—even though the patient did help to build it.

Clearly, many sorts of interpersonal factors are important in establishing and maintaining a doctor-patient relationship of the kind that will tend to promote insight. If the doctor is viewed by the patient as a well-trained competent person who is warm and friendly and who will do his utmost to help him, if the patient feels "safe" with the doctor, whether against sexual aggression or the betrayal of professional trust, if the patient believes that his fantasies and impulses and actions will be understood by a scientifically informed ally instead of attacked by a perhaps vindictively motivated critic, if all these and possibly some other conditions are fulfilled, then the presence of the doctor and the implied positive state of the transference would in general favor the occurrence of dynamic insight. For such a relationship would tend to reduce the intensity of negative secondary drives in the patient, such as shame, guilt, and fear, thus reducing superego anxiety and increasing "ego strength" to the point where previously unbearable facts about oneself become bearable, if not without moral pain, then at least with some gain in inner fortitude and capacity "to take it."

Other factors in the total situation may have a similar good tendency. Thus, after a psychoanalysis is well under way, the patient may feel satisfaction in the fact that he is "doing right" in following the basic rule, that he is bringing up "difficult" material, and in thus overcoming resistances—in facing the facts about himself and acting "like a man"—he is winning the approval of that imposing father figure, his doctor—itself perhaps an emotionally corrective experience of no little importance to the patient. The doctor's interest in this emotionally charged material is usually obvious to the patient and the patient accordingly feels better now that he is giving the doctor what he wants. This "feeling better" expresses reduced tension, and since this leads to further recall of pertinent material, a benign circle is set up—at

least for the time being. Since the patient is now, so to speak, producing freely and autonomously what the doctor wants to hear, the patient does not have to be pushed, and the strain, which the doctor had perhaps to put on the patient to get earlier related material, may now be lessened with the result of a further increase in the warmth and in the general air of relaxation that pervades the doctor-patient relationship.

This favorable atmosphere facilitates the necessary relearning on the part of the patient. The reduction in the intensity of negative secondary drives results in a better hedonic balance or in an improved realignment of emotional vectors in the patient's personality. This over-all positive gain, since it accrues to the patient in the same situation as the cognitive acts of insight, tends both to promote the insight and to consolidate it, once it has occurred. It does more. In reducing resistances, it acts like a psychic enzyme, a kind of "spreading factor," which favors the extension of the insight, its carry-over to other basically similar conflicts in the personality. Ideally, the insight is generalized and is applied to as many relevant cases as possible. One "sees" the pattern. But what is even more important, he sees it at a time when the rigidities of old habits are softened up, become less brittle and more malleable, owing to the favorable emotional climate—the optimal temperature to make the reaction "go" and to yield "results."

If a loose, though harmless, chemical analogy may be permitted, the patient's ideas (in such a setting) may, like compounds, go into solution, and their cathexes be altered owing to the electron shifts involved, with the consequence that new compounds, new configurations of meaning, with different causal properties, are formed, which have a different position in the electromotive (or motivational) series. If this new position is maintained, or if—to change the metaphor, and move to a higher level of biological integration—the insight is "assimilated," instead of just going in one end and out the other, the personality is so far more or less permanently restructured. In hysterical personalities that are highly unstable, with extremely labile autonomic responses, such restructuring is notoriously impermanent. On



the other hand, in treating cold, rigid obsessional characters there is the opposite problem, *i.e.*, how to "get at" the patient at all, in his frigid isolation, to establish good rapport, to warm him up, to soften resistances, and to penetrate repressive barriers, in short, to bring about any basic change, even temporarily, in his personality structure.

We have said above that insight, by definition, is true. From this it follows that if an interpretation, offered by the therapist, is false, and if nevertheless (or perhaps therefore) it is believed by the patient, the patient has not gained insight, but simply fallen, along with the therapist, into error. Now while this conclusion is logically valid, it raises psychologically more questions than it answers. For surely it is a naive oversimplification of the tangled facts to assume that it is the *truth* of a given interpretation, whether given to the patient by the therapist or arrived at by the patient independently, that determines its therapeutic efficacy. Therapists with a scientific orientation and a liberal faith in rational self-determination have a strong tendency to believe that if only they can induce, by means logically fair or foul, a patient to believe the truth about himself, particularly certain hypotheses about the unconscious psychogenesis of his symptoms, the therapist's battle is well on the way to being won. This *may* in some cases be so, but it raises—and does not answer—the question whether this beneficial effect is due to the *truth* of the hypotheses or merely to the fact that they *are believed*. It is faith (we have been told) that moves mountains, not the truth. To be sure, we have also been told that the truth shall make us free—not to mention the old Greek adage that "a whopping lie often availeth much"! But we can hardly settle the problem before us by appeals to such proverbs and clichés.

Unless we adopt a rather crude version of the pragmatic definition of "truth," it is misleading, we think, to talk as if the aim of a therapist in making interpretations is to state hypotheses that are true. By this we of course do not mean that his aim is to make *false* interpretations! Rather, the point is that in this sort of clinical situation language is being used not with the aim, primarily, of communicating facts to the patient, but with

the aim of altering the patient's motor-affective attitudes, and through them his symptoms and behavior, by means of well-timed interventions. These interventions may take the form of statements about early traumatic episodes and their pathogenic significance in relation to some current attitude or symptom, or they may indeed be fairly elaborate "constructions" designed to fill some hiatus in the anamnestic material, and *if* so they do of course claim to be true, *i.e.*, correct descriptions of past events and (perhaps) their causal relations to later behavior. If this is the case, then the truth-claims thus expressed are to be justified by empirical inquiries into the facts described, and whether or not such interpretations "work" therapeutically, *i.e.*, relieve symptoms or help to cure the patient, is logically irrelevant to the truth-values of the statements asserted. Hence, to infer, as some optimistic therapists are inclined to do, from the fact that an interpretation *does* "work" (*itself*, mind you, a proposition usually impossible to prove) that the interpretation is *therefore* true, is to fall into an egregious *non sequitur*; for the obvious reason that the facts that would prove that the interpretation works are entirely independent of and separate from the facts necessary to prove that the historical and causal hypothesis is true. This being so, the truth-values of the two statements (or sets of statements) are logically independent of each other, and hence from the truth or falsity of the one no inference can be validly drawn as to the truth or falsity of the other.

Experienced psychotherapists, as we all know, may hold different views as to their primary function and as to the comparative efficacy, in a given sort of case, of suggestion, catharsis, re-education, or insight. Also they may disagree as to the extent that therapy can be and ought to be "directed." But even if some form of insight therapy is decided upon as the method of choice, its controlling aim should probably not be to *tell* the patient any part of the truth about himself, but rather (we suggest) to bring about through minimal activity, if possible, desirable changes in the patient, to stimulate him to talk freely, with a spontaneous release of

affect, about charged material, and to help him to understand better the role of intrapsychic factors, along with that of precipitating circumstances, mostly other persons' actions and inactions, in causing recurrently various symptoms and difficulties in his life. In other words, the therapist intervenes, both with conventional forms of speech and various kinds of nonverbal signs, in an attempt to *stimulate insight* that will be emotionally reinforced and hence dynamically effective (at least to some useful degree) in bringing about a more favorable balance of the psychodynamic factors that determine the patient's behavior. The conventional forms of speech, if the therapist is suitably inactive, are more often separate words, phrases, hints, queries, various expressions of interest and noninterest, as well as a wide range of other attitudes, than those forms of speech we call declarative sentences, which express, in logically proper form, true or false propositions. Such minimal procedures, our experience indicates, are more likely to bring about good therapeutic results, with correspondingly minimal risks of unnecessary arguments and other undesirable intellectual and social involvements with the patient.

Does this mean that truth as a logical norm is to be ignored in making interpretations? No, of course not. But the important factor here is not truth, as such, but *relevance* of the truth, psychologically, to the patient's problems. If the therapist knows enough he can formulate a number of equally true propositions about the patient's psychosocial history. But what is needed, and what is more difficult to do, is to formulate *the* interpretation that, in the given setting, will be most likely to stimulate dynamic insight and through this to resolve conflicts and to alter favorably object-cathexes. Such dynamic insight, when it is into something really fundamental, gives the patient a kind of master key, which he may use, both at the time and at other times outside the treatment situation, to unlock a number of closed doors to dark compartments in his unconscious. Such insight will at least enable him to come to grips more effectively, in the light of increased self-knowledge, with the pathogenic monsters lurking therein, which—it is some-

times rather hopefully assumed—can only flourish, like some noxious fungi, in the dark.

As this resort to metaphor betrays, we do not know enough to describe, in literal and exact terms, all that happens in a patient who responds to a given interpretation in the course of insight therapy. Even with the sort of extensive and detailed knowledge yielded by a long and successful analysis, many dark, yet presumably relevant, areas of the personality will be left unilluminated. Since, too, the patient is, willy-nilly, responding not only to "controlled" verbal interventions, but also to numerous other stimuli in the total situation, many of them operating at subliminal levels, God himself would find it difficult to weight correctly the relative importance, for therapy in a given case, of insight-stimulating interventions. To understand may be to forgive, not only others but oneself, and this may reduce the intensity of both conscious and unconscious guilt feelings. But unfortunately tears and darkness are caused by many things, and the human psyche, even after the last flash of insight, will in all likelihood contain unintelligible surds that no rational formula can express and destructive impulses that no therapeutic maneuver can eliminate. In view of the extravagant claims not infrequently made these days for this or that brand of therapy, competing for public attention and public support, these reminders of our human finitude are perhaps in order.

But let us conclude on a more optimistic note. With increased concern, on the part of serious workers, to record full interview materials, with the logical analysis of such materials and the consequent formulation of testable hypotheses about the relative efficacy of different forms of psychotherapy, with more critical questioning of assumptions and methods and less dogmatic theorizing about issues naively interpreted in an all-or-none fashion, with such advances in data gathering, logical thinking, and hypothesis testing, we may reasonably look forward to a time, in the not too distant future, when we can really answer the question, what is the role of insight in psychotherapy?



## LONG-TERM PROGNOSIS IN MENTAL ILLNESS<sup>1</sup>

### A THIRTY-YEAR FOLLOW-UP OF 141 MENTAL PATIENTS

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There have been very few long-term studies of the outcome of mental illness. Bond and Braceland(1) in 1937 reported on 628 consecutive admissions to a private mental hospital as seen 5 years later. Only 7.6% of this group were lost but a 5-year follow-up is not as "long term" as we could wish. The report of Fuller(2) in 1935 gives the status of 80% of the discharges from several New York state hospitals after 10 years, but the loss of 20% of the cases detracts seriously and the study is incomplete in terms of prognosis, for we are not told anything about the group from which these discharged patients came.

The present authors wished to follow-up a cross-section sample of admissions to Massachusetts state hospitals in 1921. We included in our study all patients (141) admitted to Westborough State Hospital soon after a diagnostic study at the Boston Psychopathic Hospital. In 10 instances, the present whereabouts of a former patient could not be learned, a loss of 7% of the total group. The reasons for these failures include deportation to a foreign country in one instance. The 23 patients now in mental hospitals were personally examined by the senior author. The 18 patients in the community were evaluated by both authors, who questioned neighbors, employers, relatives, physicians, and social agencies knowing the patient and wherever possible, the patient as well. Where the community accepted a former patient as mentally normal, we have recorded the condition as recovered. Improvement, as recorded in this study, means productively occupied within physical capacity in spite of some symptoms and residing on an unlocked hospital ward or in the com-

munity. A patient is not considered recovered from an alcoholic psychosis if addiction led to death or persisting difficulty.

In every instance, we tabulated the following facts: hospital admissions and diagnosis, age on admission to Westborough State Hospital, age at death, time spent in hospital, mental condition on discharge and now (if living), mental condition before death, present residence or residence at death, and cause of death.

### RESULTS

The 10 patients lost track of were 2 alcoholic psychoses (recovered at discharge), a recovered depression, and improved melancholia, 2 improved manics, an unimproved (deported) paranoid, an improved schizophrenic, 1 improved and 1 recovered unclassified psychosis.

Of 23 patients now in mental hospitals, 4 are improved: a depression, a paranoid schizophrenic, and 2 mental defectives. The 19 unimproved are 11 hebephrenics, 3 paranoid, 2 catatonic and a simple schizophrenic, a manic, and a paretic.

Sixty patients died in mental hospitals and 30 died at home. Causes of death are given in Table 1, according to age at death by decade, for all deaths. Of the group who died in hospital, one was mentally improved prior to death, a depressed senile. The 59 unimproved include 23 dementia praecox patients of whom 9 died of tuberculosis, 10 arteriosclerosis, 9 paretics, 6 alcoholics, 3 involuntaries, 2 seniles, 2 epileptics, and 4 others, one each.

Of 18 patients at home, 12 are recovered, including 5 who were last diagnosed as dementia praecox. Others who are recovered include 4 manic-depressive manics, one alcoholic hallucinosis, and 2 psychoses with psychopathic personality. Two are unimproved, a paranoia and a drug-addicted psychopath. Four are improved, a neurasthenic,

<sup>1</sup> Read at the 107th annual meeting of The American Psychiatric Association, Cincinnati, Ohio, May 7-11, 1951.

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a general paretic, a hebephrenic, and a mental defective.

Of 30 patients who died at home, 22 were considered recovered prior to their final physical illness, including 8 who were last diagnosed as dementia præcox. Others who recovered include 3 manics, 3 melancholias, 5 depressions, 1 alcoholic psychosis, and 2 unclassified psychoses. Six were unimproved, 2 paranoid seniles, 2 chronic alcoholics, 1 mental defective, and 1 D.P. paranoid. Two were improved, a general paretic and a psychasthenic.

the Boston Psychopathic Hospital in 1921, and the last Westborough diagnosis are given in Table 2. Of interest in comparing the 3 diagnoses is the disappearance of the category, paranoid condition, after the patient left the Boston Psychopathic, and the sixfold increase of incidence of catatonic diagnoses. The longer a patient remains in hospital, the greater is the frequency of a hebephrenic diagnosis as is shown by the threefold rise and eventual predominance of this diagnosis over all other types of dementia præcox.

TABLE 1  
CAUSE OF DEATH AND AGE AT DEATH

|                                | Ages  |       |       |       |       |       |       | Total |
|--------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|
|                                | 20-29 | 30-39 | 40-49 | 50-59 | 60-69 | 70-79 | 80-89 |       |
| Arteriosclerosis .....         | ..    | ..    | ..    | 3     | 4     | 3     | ..    | 10    |
| Tuberculosis .....             | 3     | ..    | 4     | 3     | ..    | ..    | ..    | 10    |
| Pneumonia .....                | ..    | 1     | 2     | 4     | 3     | 2     | 2     | 14    |
| Heart disease .....            | 1     | ..    | 1     | 3     | 6     | 4     | 1     | 16    |
| Ulcer .....                    | ..    | 1     | ..    | ..    | 1     | ..    | ..    | 2     |
| Paresis .....                  | 1     | 3     | 2     | 1     | 1     | ..    | ..    | 8     |
| Suicide .....                  | ..    | 1     | 2     | ..    | ..    | ..    | ..    | 3     |
| Diabetes .....                 | ..    | ..    | ..    | 2     | 1     | ..    | ..    | 3     |
| Cerebral hemorrhage .....      | ..    | ..    | 1     | ..    | 2     | 2     | ..    | 5     |
| Nephritis .....                | ..    | ..    | ..    | 2     | 2     | ..    | ..    | 4     |
| Alcoholism .....               | ..    | 1     | 1     | 2     | ..    | ..    | ..    | 4     |
| Cancer .....                   | ..    | ..    | ..    | ..    | ..    | 3     | ..    | 3     |
| Epilepsy .....                 | ..    | ..    | ..    | 1     | ..    | ..    | ..    | 1     |
| Multiple sclerosis .....       | ..    | ..    | ..    | ..    | 1     | ..    | ..    | 1     |
| Asphyxiation, accidental ..... | ..    | ..    | 1     | ..    | ..    | ..    | ..    | 1     |
| Cellulitis .....               | ..    | 1     | ..    | ..    | ..    | ..    | ..    | 1     |
| D. P. catatonia .....          | ..    | 1     | ..    | ..    | ..    | ..    | ..    | 1     |
| Aneurysm, thoracic .....       | ..    | ..    | ..    | 1     | ..    | ..    | ..    | 1     |
| Pancreatic cyst .....          | ..    | 1     | ..    | ..    | ..    | ..    | ..    | 1     |
| Fracture, hip .....            | ..    | ..    | ..    | 1     | ..    | ..    | ..    | 1     |
| Totals .....                   | 5     | 10    | 14    | 23    | 21    | 14    | 3     | 90    |

#### DIAGNOSIS

The 141 patients were necessarily admitted to at least 2 mental hospitals. Of these, 52 were admitted to a third, 16 to a fourth mental hospital. There was significant diagnostic disagreement in 36 instances. A change from involutional melancholia to manic-depressive psychosis, from paranoid condition to dementia præcox, paranoid type, or from psychosis with cerebral arteriosclerosis to senile psychosis was not considered significant. A change from manic-depressive to general paresis, or from paranoid condition to hysteria was considered significant. The last hospital diagnosis, the diagnosis made at

#### DEATHS

Ninety deaths occurred in the 131 patients found. Of 9 patients admitted in the 2nd decade of life, only 2 are dead after 30 years. Of 28 patients admitted in the 3rd decade, 13 or nearly half are dead. Of 28 admitted in the 4th decade, 16 are dead. Of 30 admitted in the 5th decade, 80% are dead. Of 19 admitted in the 6th decade, 1 survives. The 13 admitted in the 7th decade and the 4 in their 8th decade all died, as indeed they should in 30 years. Of the 30 patients who died at home, one was admitted in the 2nd decade, 4 entered in their 3rd decade, 5 in their 4th decade, 7 in their 5th, 8 in their

6th, 3 in the 7th, and 1 entered in the 8th decade. Of the 60 who died in the hospital, one was admitted in the 2nd decade, 8 in the

accounted for 14; arteriosclerosis for 10; pneumonia for 9; cerebral hemorrhage for 5; cancer, neurosyphilis, and nephritis for

TABLE 2  
DIAGNOSES IN 141 PATIENTS

| Diagnosis   | Patients in this category by last hospital * | Patients in this category by B.P.H., 1921 | Patients in this category by Westboro S.H. |
|---|--|---|--|
| Dementia præcox                                   |  |   |  |
| Simple .....                                      | 1  | 4   | 0  |
| Hebephrenic .....                                 | 20   | 7   | 19   |
| Catatonic .....                                   | 18   | 3   | 19   |
| Paranoid .....                                    | 17   | 21  | 20   |
| Other types .....                                 | 1  | 4   | 1  |
| Manic-depressive psychosis                        |  |   |  |
| Manic .....                                       | 9  | 12  | 8  |
| Depressed .....                                   | 6  | 5   | 5  |
| Mixed .....                                       | 0  | 3   | 1  |
| Circular .....                                    | ..   | 1   | ..   |
| Other types .....                                 | ..   | 3   | ..   |
| Involuntary psychosis, melancholia .....          | 7  | 5   | 7  |
| Paranoid condition .....                          | 0  | 12  | ..   |
| Paranoia .....                                    | 1  | 1   | 1  |
| Senile psychosis                                  |  |   |  |
| Paranoid .....                                    | 2  | 1   | 2  |
| Presbyophrenic .....                              | 0  | ..  | 1  |
| Simple deterioration .....                        | 2  | 2   | ..   |
| Confused and agitated .....                       | 1  | 1   | 1  |
| Other types .....                                 | ..   | 1   | ..   |
| Psychosis with cerebral arteriosclerosis .....    | 10   | 5   | 9  |
| Psychosis with organic brain disease .....        | 1  | 3   | 1  |
| General paresis .....                             | 12   | 11  | 12   |
| Traumatic psychosis                               |  |   |  |
| Deterioration .....                               | 1  | ..  | 1  |
| Delirium .....                                    | ..   | 1   | ..   |
| Psychosis with epilepsy, deterioration .....      | 2  | 2   | 1  |
| Psychosis with mental deficiency .....            | 5  | 2   | 4  |
| Psychosis with psychopathic personality .....     | 2  | ..  | 1  |
| Alcoholic psychosis                               |  |   |  |
| Paranoid .....                                    | 2  | 2   | 2  |
| Deterioration .....                               | 1  | ..  | 1  |
| Delirium tremens .....                            | 2  | ..  | 2  |
| Acute hallucinosis .....                          | 1  | 6   | 1  |
| Chronic hallucinosis .....                        | 4  | 3   | 5  |
| Other types .....                                 | 1  | ..  | 1  |
| Psychosis due to drugs .....                      | 1  | ..  | ..   |
| Undiagnosed psychosis (unclassified) .....        | 4  | 11  | 6  |
| Psychoneurosis                                    |  |   |  |
| Hysteria .....                                    | 1  | 1   | 2  |
| Neurasthenia .....                                | 1  | ..  | 1  |
| Psychasthenia .....                               | 1  | ..  | 1  |
| Reactive depression .....                         | ..   | 1   | ..   |
| Psychosis with somatic disease .....              | ..   | 3   | ..   |
| Without psychosis, psychopathic personality ..... | ..   | 3   | 1  |
| Not insane .....                                  | 4  | 1   | 4  |
|   | 141  | 141                                       | 141  |

\* Last diagnosis differed significantly from B.P.H. (1921) diagnosis in 36 patients.

3rd, 11 in the 4th, 17 in the 5th, 10 in the 6th, 10 in the 7th, 3 in the 8th decade.

Among the 59 deaths occurring in those admitted after the age of 40, heart disorders

3 each; tuberculosis, diabetes, and suicide for 2 each; and fractured hip, ruptured thoracic aneurysm, multiple sclerosis, epilepsy, alcoholism, and asphyxiation by a

foreign body in the larynx accounted for 1 death each. Two of the 3 suicides occurred at home and none was a primary depression.

Of the 90 patients already dead, the median period of hospitalization since 1921 was 33 months. In 30 patients, the period was less than 1 year. In 22 patients, the period of hospitalization had been over 10 years.

Among the 31 patients now dead who were admitted below the age of 40, tuberculosis killed 8; general paresis and pneumonia each killed 5; alcoholism killed 3; heart disease and peptic ulcer accounted for 2 each; suicide, nephritis, pancreatic cyst, diabetes, cellulitis, and catatonia for 1 death apiece.

Among 32 dementia praecox patients who died, 10 died of tuberculosis, 7 of heart disease, 6 of pneumonia, 3 of nephritis, and 6 of 6 other miscellaneous causes including 1 suicide and 1 unexplained sudden death in a catatonic.

#### DISCHARGES

Of the 141 admissions, 68 or 48% went home (including 3 who escaped successfully). Of the 65 discharged from Westborough to their homes, 20 were readmitted there or to other mental hospitals, some 31% of those discharged. Of readmissions, 55% again were discharged, so that 41% of the 141 admissions are now, or were at their death, in the community. The median duration of hospitalization for those who left the hospital was 9 months. In 8 of these, hospitalization was 10 years or more and for 8 cases it was less than 3 months. The median duration of hospitalization for those alive at home was 12 months and, of these 18 cases, 4 were hospitalized for less than 6 months and 4 for 20 or more years. Of those discharged, 19 were recovered at the time of discharge, but 3 relapsed and 4 could not be traced.

An additional 22 recovered after their discharge for a total of 34 or 26% of 131 traced. Of the 18 surviving patients known to be in the community, 12 (or  $\frac{2}{3}$ ) are recovered.

The dementia praecox group constituted 42% of the admissions and 37.5% of the discharges, 38% of recoveries, 36% of deaths, 33% of the surviving patients in the community, and 80% of surviving hospitalized patients after 30 years. Where the last

hospital diagnosis was accepted as valid, 23% of the dementia praecox group recovered. An additional 6% were much improved. Of cases where no significant disagreement existed as to diagnosis with successive admissions, only 13% of the dementia praecox group recovered. Two of the recovered dementia praecox cases left the hospital only after 20 years. Both these patients are self-supporting and are accepted by their employer as normal.

The manic-depressive and involutional melancholias constituted 15% of the admissions, 31% of discharges, 44% of recoveries, 13% of deaths, 9% of surviving hospital patients, and 22% of surviving patients in the community. Of this group, 75% were recovered at death or after 30 years and an additional 5% were much improved.

Case summaries of 2 cases of dementia praecox who recovered after 21 and 23 years of hospitalization follow.

*Case H. H.*—A 14-year-old, Russian-American Hebrew boy, attending the 9th grade, entered the Boston Psychopathic because of 5 months of loss of interest and one month of talking strangely, avoiding people, and making stereotyped movements. The next oldest sibling was admitted a short time later for a similar disorder for which she is still hospitalized. He accused his father of wishing to kill him, said his mother pinched him in the night, that he received messages from unseen voices, and knew more than the doctors. He was diagnosed D.P. hebephrenic, discharged against advice after 5 days and admitted to Westborough State Hospital 2 months later where the same diagnosis was made. His adjustment was poor for many years but improved markedly after 20 years. He was then boarded out on a nearby farm. He made a trustworthy and intelligent farmhand and has been steadily employed on a dairy farm the past 10 years. His kindly employer now considers him quite free of mental trouble. The patient states he has to guard against a tendency to daydream but is otherwise well and enjoys being responsible for the milking machines. He is considered a social recovery.

*Case B. C.*—A 21-year-old, idle, white youth was first admitted, March 8, 1921, to the Boston Psychopathic Hospital, after 7 years of personality change and a few days of belligerent behavior toward his parents. After discharge from the Navy for cause at 17, he feared poison in his food and on his clothing. He imagined he was to be married, seized his mother's broom from her and broke it, struck his father, whom he imagined to be laughing at him. An older brother had already been hospitalized for a similar disorder. In the hospital, he

said men put him into a trance and played electricity upon him because they knew a girl who injected him with cocaine 3 years before. He was diagnosed D.P. hebephrenic and transferred to Westborough State Hospital, where the diagnosis was changed to D.P. paranoid. He was successively transferred in 1930 to Metropolitan and to Bedford Veterans' Mental Hospital. He showed gradual improvement and was released in July 1943. He found war industry employment in a rubber factory, then married and now owns his home, is prosperous and well. He is considered a social recovery.

#### SUMMARY

All of the 141 patients admitted in 1921 to Westborough State Hospital soon after study at the Boston Psychopathic Hospital were investigated 30 years later. Only 7% of the group could not be traced.

The study included age, diagnoses, time spent in hospital, condition on discharge, community adjustment, age at death, and cause of death.

In this cross-section sample, 26% of all admissions traced were recovered before death or when seen after 30 years. It was noteworthy that the dementia præcox patients, constituting 42% of the group, accounted for 39% of the surviving patients in the community and 35% of all recovered patients. Where no significant diagnostic disagreement occurred throughout successive hospitalizations, only 13% of dementia præcox patients were recovered. Where the last hospital diagnosis was accepted as valid, 23% of dementia præcox patients were recovered at death or when seen after 30 years and an additional 6% were much improved.

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# AN INQUIRY INTO EIDETIC IMAGERY WITH PARTICULAR REFERENCE TO VISUAL HALLUCINATIONS<sup>1</sup>

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## I. PURPOSE

It is the aim of this inquiry to investigate a presumptive relationship between eidetic images and psychopathological hallucinations. The hypothesis that is to be given experimental study may be stated as follows:

If certain individuals have the ability to project extremely vivid visual images that characterize an eidetic image, then this faculty is a potential function of visual hallucinations.

Hence the immediate concern of our inquiry was to test the existence of eidetic types in subjects with histories of visual hallucinations. The inferential assumption that may be derived from the stated hypothesis is that an eidetic predisposition is an important factor in the etiology of hallucinations.

## II. INTRODUCTION

In general, it is recognized that one of the important phenomena in the field of perception is that of the eidetic image. The word eidetic (Gk. *eidos*) literally means that which is seen, and conveys the psychological notion of an especially vivid image in one or more of the sensory fields. Busse(4) has defined the optical eidetic image in the following words:

Unter subjektiven Anschauungsbildern versteht man die Fähigkeit seinen Sinneseindruck nach kurzer oder längerer Zwischenzeit mit sinnlichen Deutlichkeit zu reproduzieren; z. B., eine optische Volage im ganz eigentlichen und wortlicher Sinne wieder zu sehen. (Under subjective eidetic images one understands the ability to reproduce with sensory clearness a sensory impression after a shorter or longer interval; for example, really to see, in the literal sense of the word, something which has been seen before.)

The eidetic image is a recalled sensitivity of exceptional clearness whose attributes can be investigated objectively. Though it is demonstrable in all sensory fields, it is par-

ticularly noted in the visual sphere. In this area it takes the form of the projection of an image after the stimulus has been removed.

Jaensch(12) recognized<sup>2</sup> that mental imagery may be viewed as eidetic when it possesses the full vividness of actual perception. Another distinguishing property is its localization in perceptual space.

Galton with his erudite analysis of psychological processes stated in reference to mental imagery(10, p. 69):

"There exists a power which is rare naturally, but I believe can be acquired without much difficulty of projecting a mental picture upon a piece of paper, and holding it fast there so that it can be outlined with a pencil."

The results of Galton's investigations showed not only that individuals varied in their imagery, but that there was no necessary connection between imagery and ability. Titchener(21) had assumed that images were the materials employed by thought. The psychological experiments at the Würzburg school found imagery to be far less important to thinking tasks than was once supposed. The validated data of the latter school apparently contradicted the Titchenerian assumptions.

Philosophically, the question of imageless thought dates back to Berkeley(2) and Locke(19). Berkeley denied the existence of abstract ideas or images and as a consequence of his logic was able to negate the notion of material substance. On the other hand, Locke recognized the existence of abstract ideas. The difference between the two views involved the question of the possibility of imageless thought.

With the description of the eidetic component in mental imagery, Jaensch(12, p. 2) initiated a psychological study of this phe-

<sup>2</sup> In 1909, he coined a new terminology for Urbantschitsch's *Anschauungsbildern* and called these special images eidetic. He designated such persons as eidetics.

<sup>1</sup> From the Psychiatric Division, Kings County Hospital.



nomenon. His analysis showed eidetic images to be somewhere between the memory- and after-image continuum, borrowing from each and yet different from each. There are 4 criteria that are said to distinguish the eidetic image from both the memory- and after-image (6, p. 367):

1. *Localization*.—The content of the eidetic image is externally projected and seen.

2. *Richness of Detail* (Clearness).—The eidetic image is characteristically superior in this respect to both memory- and after-image.

3. *Selection and Interest*.—The capacity to arouse an eidetic image varies with the interest in the material concerned.

4. *Persistence*.—The eidetic image not only persists through long periods of time but may be revived at will.

Allport (1, p. 418) contests the Jaenschian hypothesis of a continuum of after-eidetic and memory-images. It is his contention that the after-image and eidetic-image have only a superficial and accidental resemblance. Their similarity is based upon visual space localization, optic muscular tension, and positive or negative chromatic after-effects. According to Allport the differences between the after-image and eidetic-image are situated in the voluntary recall of the eidetic-image, its longer duration in the visual field, and its arousal by a complicated and detailed object. Allport (1, p. 420) believes that the eidetic-image is merely a limiting form of the memory-image.

O'Neil and Rauth (17, p. 16) contrast the eidetic phenomenon with a hallucination. They indicate that the eidetic image is based on something seen before and perceived with great vividness by the observer. It is never confused with objective reality, hence escaping the stigma of a hallucination.

On the other hand, Jeliffe (13, p. 82) is of the opinion that an atavistic trait may be involved in eidetic imagery, and that this ability represents a probable stage of psychic evolution. Jaensch (11, p. 19) has postulated that the eidetic function is a phase of normal psychological and physiological development with its maximum occurrence between 6 years and puberty. He states (p. 85) that "all children have not got eidetic

images," though hemieidetic<sup>3</sup> perception of the external world by most children closely parallels the eidetic phenomenon.

In the field of abnormality, Klüver (15) points out that there are no normal or abnormal images, but only normal or abnormal possessors of the image. Schilder (20, p. 601), in treating of the problem of imagination, after-images, and hallucinations, states that the eidetic image and hallucination have similar structures based upon their transpositions (in space) of movement, shape, and color.

Miller (17, p. 14) expresses the belief that the eidetic image bears a relationship to constitutional endowment as well as to certain abnormal activities, which in its persistence into adult life contributes an undertone to hallucinosis. He suggests that such an ability is substance out of which the total fabric of the psychosis may be woven. Thus an eidetic endowment may function as a potential base for psychopathology involving hallucinatory experiences.

In order to test empirically the experimental hypothesis, a research project was designed to investigate the existence of eidetic imagery in individuals with an anamnesis of visual hallucinations.

### III. METHOD AND PROCEDURE

The experimental setup was designed to test for eidetic imagery via analytic introspection in subjects with histories of visual hallucinations. It was necessary to utilize a control group free from hallucinatory experiences. The subjects used for this study were patients of the psychiatric division of the Kings County Hospital. Three psychopathological groups were tested, namely, 20 alcoholics with visual hallucinations (*i.e.*, 12 alcoholic hallucinosis and 8 delirium tremens), and their 20 respective controls (*i.e.*, 20 acute and chronic alcoholics).

It should be noted that visual hallucinations in delirium tremens are primarily entoptic.<sup>4</sup> Toxic factors such as alcohol give

<sup>3</sup> Hemieidetic is a term employed by Jaensch to describe children's perception where real perceptual objects are perceived and reacted to in a manner similar to eidetic images.

<sup>4</sup> Visual experiences having no adequate stimuli, but due to mechanical or chemical conditions of the optic connections (7, p. 45).

rise to the hallucinations upon the removal of the drug. These visual experiences may also have their psychological concomitants, but their entoptic character is basic.

Alcoholic hallucinosis differs from delirium tremens in that the hallucinations are not dependent directly upon the specific stimulation of peripheral sense organs. The alcohol sets the occasion for the syndrome rather than being its cause. The causative agent is usually of psychogenic origin and the hallucinations a function of constitutional and emotional factors.

Though the etiologies of these hallucinatory states differ genetically, they are phenomenologically related and in this respect can be studied as visual phenomena *per se*.

A neutral gray cardboard measuring 50 cm.  $\times$  50 cm. served as a projection screen, which was inclined at approximately 80° from the surface of the table upon which it rested. Across the screen, 5 cm. from its base, a narrow neutral gray card ran horizontally, which served as a support for the stimulus pictures. Daylight illumination was employed throughout the experiment with the source of light being behind the subject.

The stimuli were presented at 50 cm. from the eyes and exposed for periods of 20 (fixating) and 35 (nonfixating) seconds respectively. A homogeneous stimulus was employed for the fixation period. This consisted of a red square, measuring 5 cm.  $\times$  5 cm., which was used to determine the nature of the after-image. The heterogeneous stimuli were complicated and richly detailed silhouettes.

Figs. 1 and 2 represent 2 of the silhouettes that were shown to the subjects.<sup>5</sup>

In the nonfixating situation, the subject was instructed not to stare at any part of the stimulus but simply to observe the picture carefully. At the end of the exposure period, the stimulus was removed and the subject asked what was actually (literally) seen on the projection screen. If no report was made, as was the case for all the nonhallucinatory controls and for certain subjects in the experimental group, the subject was asked to report what he could remember.

<sup>5</sup> All the silhouettes were adopted from Bennett (3).

All those details of the stimulus were recorded and comprised the memory-image report (*i.e.*, immediate recall).<sup>6</sup>

If an eidetic image was reported, the duration and the number of reported details were noted.



FIG. 1

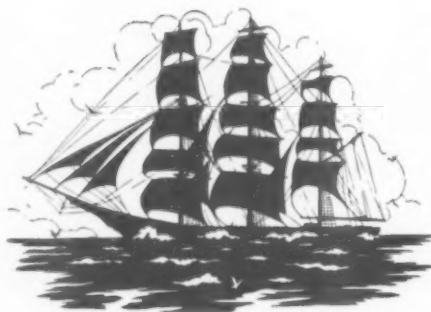


FIG. 2

Four complicated silhouettes were used because of their capacity for arousing strong sensory impressions.

<sup>6</sup> No sharp line can be drawn between memory-images and memories. They are both related to the act or process of remembering. Memories are reproductions of general ideas or meanings. Memory-images are more lifelike and vivid reproductions of sensory situations.

The rationale underlying this method has been derived from modified Jaenschian techniques (12, pp. 4-9).

In a second part of the experiment, the 3 subjects who reported eidetic images were examined one hour after exposure to the silhouettes in order to determine the persistence of these images.

#### IV. RESULTS

In Table 1 are found data pertaining to the subjects tested. Of the 40 subjects there were 30 males (16 experimental and 14 control subjects) and 10 females (4 experimental and 6 controls). All the control subjects were diagnosed as acute and chronic

alcoholics. They had a mean age of 44 years. The experimental group contained 12 alcoholic hallucinosis and 8 delirium tremens subjects with a mean age of 42 years.

Table 2 presents the results of 20-second exposure and fixation in the experimental and control subjects. It will be noted that all the images elicited under these conditions are negative. There are no qualitative or critical quantitative differences between the 2 groups. Both the experimental and the control subjects reported negative after-images after fixation with no significant statistical differences in mean duration ("t-score" .50) or mean size ("t-score" .83).

Of the 40 subjects in the experimental and control groups, none gave gross indication of an eidetic disposition with the homogeneous stimulus (*i.e.*, report of positive after-images). With the use of the silhouettes 3 of the experimental group reported eidetic images, while no control subject reported an eidetic image.

Table 3 records the eidetic imagery reported by the 3 subjects with hallucinatory experiences after the removal of the complicated stimuli (II-V) as viewed without fixation for 35 seconds.

TABLE 1

##### DATA CONCERNING THE SUBJECTS TESTED

|                                | Experimental | Control |
|--------------------------------|--------------|---------|
| Number of subjects.....        | 20           | 20      |
| Sex:                           |              |         |
| Male .....                     | 16           | 14      |
| Female .....                   | 4            | 6       |
| Acute and chronic alcoholics.. | 0            | 20      |
| Delirium tremens.....          | 8            | 0       |
| Alcoholic hallucinosis.....    | 12           | 0       |
| Age range.....                 | 30-50        | 31-54   |
| Mean age.....                  | 42           | 44      |

TABLE 2

##### RESULTS OF AFTER-IMAGE TESTING

(20 seconds with fixation—homogeneous color stimulus)

|   | Experimental<br>(20 subjects) | Control<br>(20 subjects) |
|---|-------------------------------|--------------------------|
| No. after-images reported.....                      | 20                            | 20                       |
| Mean duration of after-images.....                  | 10.4 sec.                     | 9.6 sec.                 |
| Range of duration.....                              | 6-20 sec.                     | 2-21 sec.                |
| "t-score" of difference between duration means..... |                               | .50                      |
| No. of positive after-images.....                   | 0                             | 0                        |
| No. of negative after-images.....                   | 20                            | 20                       |
| Mean size of image at 50 cm.....                    | 5.75 cm. sq.                  | 5.50 cm. sq.             |
| Range of sizes at 50 cm.....                        | 3.75-7.50                     | 3.75-6.88                |
| "t-score" of difference between size means.....     |                               | .83                      |

TABLE 3

##### ANALYSIS OF REPORTED EIDETIC IMAGES

(30 seconds without fixation—silhouettes)

| Silhouette | Mean duration | Range of duration | Mean No. of details | Range No. of details | Total details |          |       |
|------------|---------------|-------------------|---------------------|----------------------|---------------|----------|-------|
|            |               |                   |                     |                      | Positive      | Negative | Wrong |
| II .....   | 76.66 sec.    | 65-90             | 8.33                | 7-10                 | 24            | 0        | 1     |
| III .....  | 70.0 sec.     | 61-95             | 9.0                 | 8-10                 | 27            | 0        | 0     |
| IV .....   | 90.0 sec.     | 77-103            | 9.6                 | 9-11                 | 25            | 2        | 2     |
| V .....    | 66.66 sec.    | 60-88             | 8.66                | 7-11                 | 25            | 0        | 1     |

TABLE 4  
COMPARISON OF EIDETIC IMAGES OF EXPERIMENTALS WITH MEMORY IMAGES OF CONTROLS

| Stimulus  | Mean number of details                   |                                     | Range of details                         |                                     |
|-----------|--|-------------------------------------|--|-------------------------------------|
|           | Eidetic images of experimental group (3) | Memory images of control group (20) | Eidetic images of experimental group (3) | Memory images of control group (20) |
| II .....  | 8.33                                     | 9.75                                | 7-10                                     | 8-15                                |
| III ..... | 9.0                                      | 9.5                                 | 8-10                                     | 7-15                                |
| IV .....  | 9.6                                      | 10.4                                | 9-11                                     | 7-11                                |
| V .....   | 8.66                                     | 9.8                                 | 7-11                                     | 6-13                                |

TABLE 5

## PERSISTENCE OF EIDETIC IMAGES

| Silhouette | Mean duration | Range of duration | Mean No. of details | Range of details | Total details |          |       |
|------------|---------------|-------------------|---------------------|------------------|---------------|----------|-------|
|            |               |                   |                     |                  | Positive      | Negative | Wrong |
| II .....   | 61 sec.       | 56-63             | 8.00                | 7-9              | 24            | 0        | 0     |
| III .....  | 50 sec.       | 46-54             | 8.66                | 8-9              | 26            | 0        | 0     |
| IV .....   | 46.66 sec.    | 45-50             | 8.33                | 7-10             | 25            | 0        | 0     |
| V .....    | 44.66 sec.    | 39-48             | 8.33                | 8-9              | 25            | 0        | 0     |

The mean duration of the eidetic images from all of the stimuli shows consistency with the range from 60-130 seconds. The number of details reported in the eidetic image range from 7 to 11 details. Of the 107 details reported in all the eidetic images, 101 were of the same color as in the silhouettes.

Table 4 presents reports of eidetic image of hallucinatory subjects aroused by complicated stimuli as compared with the memory-image reports made upon the removal of the same stimuli by nonhallucinatory subjects.

This comparison was made in order to show the relationship in content arousal of eidetic and memory images between the 2 groups. All the controls and 17 experimental subjects reported memory images after the initial exposure of each silhouette. Out of 80 exposures to the experimental group, 12 eidetic images were reported. The memory images were given in more detail than the eidetic images, and were more variable in the number of details reported.

It is relevant to note that of the 3 subjects who reported eidetic images, one was a delirium tremens patient, and the other 2 were in the alcoholic hallucinosis classification.

It is a general assumption that eidetics have the ability to revive voluntarily images previously experienced. Table 5 throws light upon this question. All 3 subjects were able to project the silhouettes one hour after original exposure, but with decrements in mean duration and number of details.

In order to calculate the probability value and hence the significance of these results, a  $2 \times 2$  table was constructed (Table 6). To determine the probability value ( $p$ ) of the data, Fisher's method of the "exact treatment of  $2 \times 2$  table" (9, pp. 96-97) was employed. The resulting  $p$  value was 11%. This means that the eidetics found in the experimental group do not differ significantly with respect to their imagery from the control subjects.

TABLE 6

TESTING THE SIGNIFICANCE OF DIFFERENCES OF THE EXPERIMENTAL RESULTS ( $2 \times 2$  TABLE)

|                               | Eidetic | Non-eidetic | Total |
|-------------------------------|---------|-------------|-------|
| Hallucinatory alcoholics .... | 3       | 17          | 20    |
|                               | (a)     | (c)         |       |
| Nonhallucinatory alcoholics.. | 0       | 20          | 20    |
|                               | (b)     | (d)         |       |
| Total .....                   | 3       | 37          | 40    |

Such results can be accounted for as a consequence of sampling variation.

It is interesting to note the relation between active hallucinosis and induced eidetic imagery. One of the subjects, a 31-year-old white male, was reported in a delirium tremens condition. Upon the presentation of stimuli II-V, he saw "snakes, elephants, three black figures bending down, trees, and faces" in diminutive sizes. There was no relation between stimulus content and the imagery aroused. In a retest, when the subject

was not actively hallucinating, he reported eidetic images with the 4 complicated stimuli.

#### V. DISCUSSION

Schilder(20, p. 607) states that in the toxic psychoses, particularly in alcoholic hallucinosis and delirium tremens, there are optical hallucinations that in their phenomenological structure are similar to the eidetic images of nonpsychotic subjects. The hallucinations in alcoholics are based upon the quantitative increase of the phenomena that can be observed in normals. Hence the so-called normal perceptual productions (whether optic or eidetic in nature) may constitute the main substance for alcoholic perceptions.

The results indicated that 15% of the experimental group manifested eidetic imagery. Since no nonhallucinatory alcoholics possess eidetic imagery, it may be that, in those 3 hallucinatory alcoholics who are eidetic, this disposition may facilitate the precipitating hallucinations. Whether this is a significant clinical finding will have to be determined by further investigations with larger samples.

A comparison of the responses to the homogeneous stimulus with fixation shows no statistical difference, although images of relatively greater duration and larger size were more commonly reported by the experimental subjects (Table 2). All the images aroused were negative. No positive after-images were elicited by either of the groups. The Jaenschian notion(12, p. 5) that the after-images should be positive in color in eidetic subjects is not confirmed.

According to the richness-of-detail criterion(6) the eidetic image is supposedly richer than the memory-image. The results show (Table 4) that the immediate memory-images are richer in detail than the eidetic-images.

The selection and interest criterion(6) did not receive total confirmation. Eidetic arousal should theoretically be a function of the material's subjective interest. It can be noted that the 3 subjects with eidetic imagery responded positively to all the presented silhouettes. None of the remaining subjects (17 experimentals and 20 controls) gave signs of an eidetic disposition.

Further corroboration that the images projected were eidetic in nature was found by testing the 3 eidetic subjects for the persistence criterion(6). All 3 were able to project their previously reported images one hour after exposure, but with a decrease in duration and number of details (Tables 3 and 5).

Jaensch(14, p. 88) advanced the view that an eidetically endowed individual in a delirium tremens condition would easily hallucinate. The responses reported by one of the eidetic subjects in a toxic state add experimental evidence to this formulation. This subject's productions were of a pseudo-hallucinatory nature and most likely entoptic in origin.

A closer analysis of hallucinatory phenomena becomes pertinent in order to understand their relation to eidetic imagery. The theories that have been evolved for an understanding of hallucinations have frequently stressed one set of factors to the exclusion of others. They have stressed "either psychological or physiological factors, peripheral or central factors, sensory or motor factors, cortical or subcortical mechanisms" (16, p. 175).

The psychoanalytic theory of hallucinations places its emphasis upon central or purely psychically conditioned factors. Coriat(6, p. 375) contends that all individuals experience what they wish to experience. If the wish becomes too intensified under certain pathological conditions, it might become transformed and projected in the form of sensory images. The reality-testing function of the ego is subsequently diminished in mental diseases accompanied by hallucinations. As a result of the schism between the ego and reality, the ego withdraws its cathected tendencies and the repressed unconscious material may penetrate into consciousness in the form of hallucinations. The resultant effect is that the repressed material now becomes the reality data of the ego. Hallucinations develop from the repudiated data of reality, id or superego.

Ferenczi(8) is of the opinion that hallucinations bear a certain relation to the development of the reality sense. The analytic view that the child at a certain stage in its development imagines or hallucinates its



wishes in order to satisfy certain inner subjective conditions coincides with Jaensch's interpretation of child maturation (12, p. 123). The psychoanalysts (5, 8) believe that the hallucinations of the adult psychotic are regressions to this period of childhood.

From a nonanalytic approach Prince (18, p. 207) views hallucinations as the arising into consciousness of normal imagery. Hence this form of mental imagery belongs to the subconscious thought and not to a regressional type of infantile thinking.

The physiological psychologists (16) maintain that peripheral or psychosensorial mechanisms are integral factors in the development of hallucinations. Hallucinations are thus attributed to "impersonal" factors, namely, organic and toxic elements that have no special relationship to personal interests, emotions, or experiences. Such phenomena are believed to appear in the patient's field of experience irrelevant of psychogenic factors.

Horax (11, p. 534) reported on visual hallucinations as found in organic brain disease. He notes that these phenomena varied from blindness to vivid perceptions of definite objects. From a neuroanatomical aspect, he points out that the crude hallucinations associated with injuries to the receptive areas of the occipital or temporal lobe may be contrasted with the more highly organized hallucinations as a result of damage to the association areas.

The fact that the visual perception of patients with traumatic lesions of the occipital lobes exhibits similar spatio-temporal changes as viewed in eidetic images and hallucinations is of significant clinical interest.

The basis for comparing eidetic and hallucinatory phenomena has been made with the data suggested from induced mescal psychoses.<sup>7</sup> Jaensch (12, p. 33) reported that noneidetic persons produced eidetic images by taking mescaline. Jaensch and Klüver entertain disparate views on the effects of mescaline. Eidetic individuals who previously saw only complementary eidetic images now viewed them in natural color. Klüver con-

tests these observations, but believes that the hallucinatory constants of form and spatio-temporal changes are common to both hallucinatory and eidetic phenomena.<sup>8</sup>

Returning to our specific inquiry, it may be said that there are doubtlessly organic changes in the perceptual field of the alcoholic that may form the organic basis for his hallucinations (*i.e.*, delirium tremens). Though hallucinations may be induced by specific pharmacological agents (*e.g.*, mescaline), by special toxins affecting the optic nerve (*i.e.*, alcohol), or by gross intracranial lesions, the particular constitutional endowment of the individual may play an important role in their development. The present experimental approach has been employed in order to understand the hallucination-eidetic relation *per se* apart from its emotional or organic relationships.

This is not to say that pathological visual phenomena do not stand in an intimate relation to the emotional life of the person. As the experiment was designed to determine qualitative-quantitative differences, no attempt was made to relate the subject's response to its underlying affective context.

Such possible experimental variables as age, sex, and intelligence were not considered as significant influencing factors in our problem.

The age factor was held relatively constant. All the subjects were beyond the critical pubertal eidetic ages. In respect to sex, the groups were not equated (10 females and 30 males) as there is no known relationship between sex and eidetic imagery (Table 1).

According to the literature (14, 17) there are no significant statistical correlations between eidetic imagery and intelligence. Eidetic cases are scattered from the feeble-minded to the superior adult.

From a genetic aspect, it is known that, as the child grows older, he becomes aware of the disparity between imagery and reality. He may therefore react to this awareness in one of 3 ways: (1) by developing a greater objectivity, (2) by accepting the situation reasonably, and (3) by seeking refuge in an imaginary world. For a mentally disturbed

<sup>7</sup> The mescal psychoses induced by mescaline (3, 4, 5, trimethoxyphenethylamine is a stimulant and antispasmodic) are characterized by hallucinations of a primitive type.

<sup>8</sup> Klüver, upon taking mescaline himself, found that he did not turn eidetic (14, p. 78).



individual, the latter choice may be enhanced by an eidetic disposition.

The eidetic endowment may function in the visually hallucinating alcoholic as a factor facilitating withdrawal into an imaginary world. It is through this process of escape from reality that a sphere of unreality is created out of which personality disorders arise.

There was no attempt to classify the eidetic subjects according to the Jaenschian notions of B, T, or BT types.<sup>9</sup> The validity of such a typological analysis to psychopathological phenomena has not been demonstrated. There are no apparent or significant connections between the Tetanoid-Basedoid symptoms and eidetic imagery according to the medical and psychological literature on this subject(17).

In order to interpret the experimental results statistically, the data were subjected to a  $2 \times 2$  table analysis as a means of noting the probability value. This rigid analysis of the data was made via the "exact treatment of  $2 \times 2$  tables" (Table 6).

According to the criteria of probability significance, a probability value of 11% is not statistically significant. That is to say, the proportionality ratio of eidetics to noneidetics within the experimental and control groups is the result of chance factors.

<sup>9</sup> The Tetanoid or T type is regarded as pathological and comparatively of small importance. Biophysically, the T type has the properties of galvanic and mechanical hyperexcitability of peripheral and motor nerves. The images related to this type are nonvoluntary, complementary, nonfluctuating, nonspontaneous, fixed in form, and close to the after-image in size.

The mixed B and T types occur most frequently (either BT or TB), according to the amount of B and T component present. The BT type is thought to be the normal type that prevails among adults and children.

The Basedoid or B type individuals tend to show the physical symptoms of Grave's disease (i.e. enlarged thyroid gland and prominent eyes.) On the biophysical side, the B type constitution is characterized by lively skin reflexes, low skin resistance, widely opened bright eyes, and ready perspiration. The B type images are voluntary, positive, fluctuating, spontaneous, and like the memory image in size (14, pp. 8-11).

## VI. SUMMARY AND CONCLUSIONS

This inquiry is an attempt(1) to obtain experimental evidence concerning the nature of eidetic imagery in alcoholic subjects with histories of visual hallucinations, and (2) to determine the relationship between eidetic and hallucinatory phenomena.

A group of 40 alcoholics (20 experimental and 20 control) were submitted to fixating and nonfixating periods on homogeneous and heterogeneous stimuli. The results were used to compare the existing differences between the 2 groups.

1. Eidetic images were reported by 3 subjects in the experimental group and none in the control group.

2. The after-images elicited by a 20-second fixated exposure of the homogeneous stimulus, reported by both experimental and control subjects, did not possess any significant qualitative or quantitative differences.

3. Eidetic images were reported one hour after exposure to the silhouettes by all 3 eidetic subjects but showed a decrease in mean duration and number of details.

4. The memory images of 20 control subjects were richer in detail than the eidetic images of the 3 experimental subjects.

5. The probability value of 11% for the experimental results is not significant and indicates the proportionality ratio of eidetics to noneidetics is a result of sampling variation.

These results do not statistically substantiate the hypothesis of a relationship between eidetic experiences and visual hallucinations. Neuroanatomical and physiological approaches to this problem have brought forth confirmatory evidence indicating a close phenomenological relationship between hallucinations and eidetic images.

It is not the purpose of this paper to equate the term hallucination with a genetically different phenomenon. The fact that the eidetic image is never confused with reality has been the *differentia specifica* between vivid mental images and hallucinations. One may say that hallucinations are mental images experienced in pathological states, while eidetic images are a consequence of a specific sensory endowment.

Both the context and structure of visual hallucinations in alcoholics may be determined by the particular optic or brain centers affected by the drug, by the psychophysical make-up of the individual, and by intrapsychic and environmental experiences.

Pending further follow-up studies, it appears that this experimental analysis shows that an eidetic endowment is not essential to the development of visual hallucinations in alcoholics.

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## SOME OBSERVATIONS ON TREATMENT IN THE TERMINAL PHASES OF HOSPITALIZATION<sup>1</sup>

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In the winter of 1948-49 we started a "Day or Night Plan" for selected patients in a 50-bed psychiatric hospital for psychotic and neurotic patients. Initially, the Day or Night Plan was perhaps narrowly conceived as an arrangement of the patient's day to allow part-time living in the hospital. Patients could either stay the night in the hospital, obtaining psychotherapy before or after return from the day's activities (the Day Plan), or patients stayed the day at the hospital, participating in the ward routine and pursuing their psychotherapeutic interviews (the Night Plan). In great measure, this manipulation of time was thought of initially as an extension of occupational therapy.<sup>3</sup>

The location of our unit among university buildings of a city and the internal structure of limited space and limited resources for diversified and appropriate recreational and occupational activities forced us to explore the peculiar facilities of the community to meet our patients' needs.

Individual values of doctors and administrators no doubt played a significant part in stressing work, gainful employment or systematized voluntary participation in jobs rather than encouraging prolonged, infantilizing living on the wards interrupted from time to time by a variety of essentially non-goal-directed distractions and unorganized play (3).

Initially, we were also mindful that patients on the Day or Night Plan would be able to reduce their hospital expenses (patients on this plan pay half the regular fee for hospitalization). The economic stress of hospitalization was further lightened by certain patients' ability to contribute with their

own earnings. We were also mindful that many patients would feel a heightening of self-esteem by reentering to some extent life in a community and would realize further gratification in work well done. The breaking down of the hospital walls, on the whole, was a salutary experience for the individual patient. The patients not yet on this plan anticipated such an arrangement as a privilege. There were comments from patients not on the plan that indicated appreciation of "patients actually getting well," or improving. Patients on the Day or Night Plan communicated their new experiences and changing interests to the general group and thereby tended to modify the rather stultified patterns of interest and discussion that obtain in the patient society hospitalized for a long period of time.

Nineteen patients have been for varying lengths of time on the Day or Night Plan. Of this number, 9 were diagnosed as psychotic and 10 as essentially neurotic (Table 1). It is not desired at this time to entertain a statistical approach. The scope of this paper does not allow the report of a detailed analysis of each case.

As patients began to engage in this modified living-in-plan, we were soon impressed that the superficial aspects, to be sure, were appreciated by patients and doctors, but that to all patients this meant emphatically a new phase in treatment and in most instances a terminal phase in treatment in the hospital setting. We would like to focus our communication on some of the problems and observations of part-time living in the hospital as a terminal phase of treatment.

Our review of the cases suggests that the patients using the Day or Night Plan be considered under 5 groupings. These groupings are admittedly arbitrary as many needs of the patients had to be considered before modified hospitalization was undertaken. The groupings, however, suggest the different, dominant problems or situations that

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<sup>3</sup> We are aware that many institutions employ one form or another of modified hospitalization. See references 1 and 2.

obtained for which the patient was placed on the Day or Night Plan.

(1) Problems of continuation of therapy at a time of conflict between complete dependence on the hospital and impulsive negation for any further need of treatment (5 patients).

(2) Problems of meeting patient's seemingly rational demands and conscious desire for work (3 patients).

(3) The needs for partial and time-limited rehabilitation by employment during early phases of recovery from acute psychotic episodes (3 patients).

or desertion. Hospitalization further implied real or fantasied rejection from significant social relationships, people connected with jobs, social organizations, schools, etc. These patients invariably came to a period of conflict where the desire to avoid such painful situations made them aware of their great dependency on the hospital and therapist. This seeming threat they tried to solve by sudden, impulsive negation of any further need of hospitalization and psychotherapy.

The use of the Day Plan allowed the patient a superficial solution to the problem, whereby, however, further psychotherapy be-

TABLE 1

| Patient | Diagnosis                 | Length of Inpatient Stay | Length of Day Plan | Length of Night Plan |
|---------|---------------------------|--------------------------|--------------------|----------------------|
| A.      | Psychoneurosis-alcoholism | 6 months                 | 2 months           |                      |
| B.      | Psychoneurosis            | 6 months                 | 5½ months          |                      |
| C.      | Psychoneurosis            | 3 months                 | 2 months           |                      |
| D.      | Psychoneurosis-alcoholism | 6 months                 | 3½ months          |                      |
| E.      | Involuntal psychosis      | 1 month                  | 5 weeks            |                      |
| F.      | Psychoneurosis            | 2 months                 | 6 weeks            |                      |
| G.      | Schizophrenia             | 4 months                 | 6 weeks            |                      |
| H.      | Schizophrenia             | 6½ months                | 1 week             |                      |
| I.      | Schizophrenia             | 3 months                 | 3 weeks            |                      |
| J.      | Schizophrenia             | 1 yr. 1 mo.              | 4 weeks            | 4 weeks              |
| K.      | Psychoneurosis            | 7 months                 | 4 months           |                      |
| L.      | Psychoneurosis            | 6 months                 | 9 months           |                      |
| M.      | Schizophrenia             | 6 months                 | 3 days             |                      |
| N.      | Psychoneurosis-alcoholism | 2 months                 | 7 months           |                      |
| Z.      | Schizophrenia             | 5 months                 |                    | 10 months            |
| Y.      | Involuntal psychosis      | 1 month                  |                    | 2 months             |
| X.      | Psychoneurosis            | 4 months                 |                    | 6 months             |
| W.      | Psychoneurosis            | 4 months                 |                    | 6 months             |
| V.      | Schizophrenia             | 3 months                 |                    | 8 months             |

(4) Short-time evaluation of patient's tolerance to stress in a nonhospital situation prior to discharge (5 patients).

(5) Gradual adaptation of chronic, psychotic patients to home environments (3 patients).

It is not an infrequent phenomenon to observe the return of considerable resistance to therapy and to hospitalization after the initial period of treatment has effected appreciable reduction of anxieties that led to admission, but before the patient has gained significant insight into his problems to modify his personality and behavior. In our series, this was particularly seen among the patients whose admission resulted from pressures exerted by relatives or physicians that in the patient's mind implied rejection

came acceptable. We would like to illustrate with the following.

CASE 1.—Patient B., a 32-year-old, single woman, was admitted to the hospital because of titubation of 4½ years' duration. Neurological investigation on 3 occasions disclosed lack of organic basis for symptoms. The onset of the tremor of the head, with associated facial tic-like movements, was initially tentatively related by the patient to a series of unsatisfactory relationships with suitors and bosses. No specific precipitating factors were known. Four months prior to admission the symptoms increased in severity and were noted to occur in relation to anxiety in the home, particularly with regard to the mother. The patient was of middle-class background, had enjoyed a good education. She had been able to support herself for several years in holding responsible positions as an administrative secretary. Initially, the patient discussed some of her personal problems including her sexual difficulties, her concern about inability to

get married and to have children, and resentment toward men and toward her mother. She felt rejected and helpless. Although the patient gave lip service to wanting therapy, it became evident after feeling some subjective improvement that her fear of dependence was so strong that she could not enter into a constructive therapeutic relationship until she was granted her wish to work while in the hospital. She started on the Day Plan 6 months after admission.

Early recognition that the patient was in a severe conflict over her deep dependency on the therapist and the anticipation that she would repeat here her need to deny completely the dependency by provocation of rejection, consciously then felt as desertion, allowed us to manipulate the patient's conscious desire "to do something" because the hours in the hospital were "boring." The patient emphasized the economic benefits of such arrangements and had also partial insight that working while in the hospital was a gesture of defiance toward her mother. Her high intelligence, previous training, and seemingly good ego control allowed her a choice of jobs. It is significant that from the available positions the patient's choice fell on a job where her superior was a dominant woman, where her co-workers were chiefly men. The resistance to therapy diminished as the patient used the Day Plan. She was able to gain some insight into some of the aspects of transference to the therapist. In good measure, the patient revived the ambivalent attachment to a brother with many sexual and destructive fantasies. The area of dependence and independence in terms of the mother and now "boss" figure was worked through to a considerable extent. It is important to point out that the patient did the most constructive work with the therapist when she thought that hospitalization was nearing an end. Indeed, the Day Plan meant to her a "terminal phase" of treatment.

The insights gained in this month's period were obviously not deep enough to resolve the titubation. There was, however, considerable improvement in the degree of titubation, some symptom-free periods. Patient did well in her work and accepted the need of further deeper insight therapy. We feel that, in this instance, the availability of the part-time living-in that the patient's ego strengths could use prevented a threatening regression to a very immature dependency level. The experiences in the new situation were therapeutically used to help the patient gain dynamically important understanding of some of her disturbing behavior. The acceptance of further therapy with another therapist was connected with the "weaning process" that was used in the hospital therapy.

The physician's judgment of the dynamic implications of work for the patient is highly important. An instance in which our consideration was unfortunately faulty illustrates the importance of this problem when entertaining the Day Plan for a patient. From the detailed examination of our mis-

take, however, we gained understanding of the importance of assessing conscious and, if possible, unconscious motivations for part-time living-in, and of keeping clearly in focus the extent, depth, and nature of the doctor-patient relationship at the time of initiating such plans. This case also illustrated the patient's concept of the Day Plan as a terminal phase in therapy.

CASE 2.—Patient F. is a 21-year-old, single, Jewish girl who was referred following a suicidal attempt with barbiturate. This patient is an attractive, intelligent, former art student, the only child of very disturbed parents. The mother is described by the patient and her father to be an obese, "dirty, lazy" woman. Parents separated when the patient was 13. The patient continued to live with her father, maintaining only minimal contact with her mother. The patient has shown evidence of emotional disturbance during most of her life. As a child, she had violent temper tantrums similar to those of her mother. She was always a moody, isolated child and has always had difficulty in making friends. Following graduation from high school, patient attended 3 art schools. She attempted in the past few months to work at several jobs, including free-lance advertising, but was unable to keep any of these positions. She has been increasingly seclusive, spending many days indoors reading. There would be episodes of despondency in which she would think constantly of suicide. During this same period the patient described "food drunks." These apparently consisted of episodes of compulsive eating in which she became fearful lest she be as obese as her mother. Two weeks prior to admission, the patient decided to end her life and waited for a time when her father would be out of town. She could, however, give no specific reasons for her suicidal attempt.

We recognized from the start that the patient had markedly ambivalent feelings to the therapist. The first period of hospitalization (4 weeks) concerned itself with repetitive expressions of denial of her illness and doubts about the therapist's competency and interest in her as a person. With the acceptance of the aggressive and hostile feelings, patient became much friendlier and more confiding and entered a second period of testing the therapist about accepting real and imaginary inadequacies in herself, the patient. She repeatedly expressed the desire to work and gave cogent arguments why it would be beneficial. We acceded to her wishes. Almost 2 months after admission the patient started on the Day Plan, working as a volunteer in a community nursery school. Toward the end of the following month she expressed doubts about her "contributions" to this work, just at a time when her efforts had been recognized as superior, and the patient was invited to consider the job on a permanent and salaried basis. On the first day of the next month, she made an attempt at suicide by taking an overdose of sleeping pills.



Our willingness to allow the patient to work on the Day Plan was based on the rationalization that, given an opportunity to work, she could recognize that she would not be rejected if she failed at this work or chose for other reasons to discontinue it. The error of our focus and our reasoning was obvious. A review of the neurotic patterns points out that issues of ambivalence in the transference and the fear that successful work would terminate hospitalization were the dominant concerns masked by the more conscious expressions of trying to prove herself worthy and successful. After the suicidal attempt, the patient herself summarized the real dynamics involved by stating that doing good work meant that she was well enough to leave the hospital, that the therapist then would not recognize how sick she was and how much help she needed, and now that she had made this suicidal attempt it would be impossible for the therapist to like her.

Problems of quite a different nature were met in the use of the Day Plan in treating patients(3) recovering from acute psychotic (schizophrenic) episodes. As the patients' overt behavior became more controlled and predictable it was considered important to minimize the exploration of fantasies and delusional thinking. The focus of the therapeutic discussions was on the immediate realities of life on the ward. At this time, organized activities were planned and part-time employment entertained. The contemplated work was decidedly different from the occupation pursued prior to illness. It was limited to a designated period of time and was conceived as the first step in a series of projects toward rehabilitation in the nonhospital world. The work was prescribed and suitable jobs were secured with the help of the social worker. We illustrate with Case 3.

CASE 3.—Patient G, a white, single male, 23 years old, who complained of tension, stammering, and episodes of nausea of many years' duration. About 2 months prior to admission, he started to have strong desires to attack people, felt he would "run amok." There were disturbing, nauseating fantasies of fat, naked, middle-aged women and of "putrefying flesh." At time of admission to hospital, patient was in a state of panic. He came from middle-class background. Father died when patient, the only child, was 1½ years old. Mother separated from stepfather, whom patient liked, when latter was 16 years old. He was very attached to grandparents. Mother has always been very ambitious for patient who has been excellent student; in college changed major interest from music to premedical courses, to philosophy. At time of onset of acute disturbance, patient was contemplating marriage to a girl who had befriended patient's mother.

When the Day Plan was started 4 months after admission, patient expressed a desire for "man's work" of a manual nature. Such wishes were in obvious conflict with the mother's attitudes, who stressed high performance in academic and artistic fields. The patient's relationship to the male therapist was positive and strong. It was correctly anticipated that the approval of the therapist would be sufficiently supporting to permit the patient to pursue his conscious desire for manual work, in this instance as a ditch-digger. The patient maintained pleasant working relationships with bosses and male co-workers. He was pleased with objective improvement. The scrutiny of the new relationships and experiences was used in therapy. The patient was able to discuss the homosexual aspects of his problem with increasing objectivity and gained some insight into his conflicts. The patient conceived of working as a last phase in treatment. Gradually, he accepted the earlier rejected need for further prolonged therapy, following discharge from the hospital.

In another group of 5 patients, the Day Plan was used in a more conventional sense of "terminal phase." The chief problem was to use short periods of one week to one month to give the patients a chance to test their tolerance to outer stresses and inner anxieties while away from the hospital. During this time, the patient was still supported by a known therapist, while making the early adjustments with a new psychotherapist in the community. To these patients, the relatively gradual change seemed essential as an abrupt breaking off from the hospital was threatening enough to attempt a delay of the planned discharge. This was at a time when the therapist was reasonably certain that patients could maintain themselves out of the hospital and already had some insight into their problems and the physician-patient relationship. These patients were put on the Day Plan to give them an opportunity to recognize that "getting well" demanded also a chance to function appropriately in the individual's essentially normal milieu.

In this small series, 5 patients were on the Night Plan. In contrast to the Day Plan, which attempted to help the patient to a high degree of independent living, the problems of our patients on the Night Plan dealt with acceptance by patient and relative of the former's limited functioning in sheltered, non-demanding environments. The Night Plan was chiefly used for those schizophrenic patients whose improvement was manifested by increasingly controlled and predictable be-

havior in spite of the persistence of some delusional thoughts and hallucinations. In our opinion these patients were not capable of living independently following discharge nor were they suitable candidates for any form of regular employment. In each instance, we felt that a gradual transfer to a sheltered home environment should be tried in lieu of transfer to a state hospital. It seemed important to us to respond to the relative improvement of these patients and their desire for change by termination of complete hospitalization. In each instance, the Night Plan was acceptable to the patient as well as his family. Indeed, we felt that the family needed considerable help through the efforts of the social worker to assimilate the patient back into the home at a time when he needed a great deal of support before he could enter into the home situation completely.

CASE 4.—Patient V., a 32-year-old, single male, was admitted following 7 months of hospitalization in another institution. The diagnosis of schizophrenia, paranoid type, was established in the latter institution. Insulin coma therapy and 31 electric shock treatments effected little improvement. At time of admission patient disclosed many ideas of reference, fairly systematized delusions, and had auditory hallucinations. He was preoccupied with his "status as man," doubted his masculinity. He was vague and withdrawn and suspicious but showed some motivation for obtaining help through psychotherapy. Patient was youngest of 3 children, raised on the parental farm. During adolescence he made a poor social adjustment in a city, but was able to pursue his education through  $3\frac{1}{2}$  years of college. Patient was 4½ years in the Air Force and is reported to have adjusted well. Following discharge, he became a lumberjack on the west coast. Present illness that led to hospitalization became manifest in 1948, characterized by suspicions, confusion, and worry about his potency. He expressed fears of castration and left his work to escape "threats" from other men.

With hospitalization, the patient became increasingly relaxed and was able to talk fairly freely about his difficulties. He was very concerned about fears of homosexuality, his status as a man and worker. Throughout his stay, he continued to have delusions that he was talked about because of his sexual conflicts. He also maintained his auditory hallucinations, voices telling him "you are dying," or later, "you are afraid of women," and "isn't it too bad he is homosexual." The patient was unable to accept initially the idea that he was not able at this time to find a job and to hold it. He repeatedly rejected the feasibility of his return to the parents and working with them on the farm. After the patient started on the Night Plan, he

made a number of unsuccessful attempts to find employment. He discussed his experiences and difficulties in great detail with his therapist. During the first month, he spent 5 days a week at the hospital, after this was seen 4 times a week for the ensuing 2 months. He not only decreased his therapeutic hours but spontaneously decreased the number of hours that he was using on the Night Plan. It was the therapist's impression that the patient brought out a great deal of significant material during this later phase of treatment. After 6 months on the Night Plan, he accepted the idea of staying in the protective environment that his parents could give him and that he could successfully carry out some work of limited scope on the parental farm.

#### DISCUSSION AND SUMMARY

In this report we have discussed a part-time hospitalization program in a small private mental hospital. Administratively, the Day or Night Plan, used by a small and selected number of psychotic and neurotic patients, did not pose any special problem. The plan afforded a significant reduction in the cost of hospitalization. It augmented, in a constructive manner, the services of the occupational therapy department and in many instances functioned as a program for vocational rehabilitation. The plan proved effective in reducing the isolation from community activities and interests for patients on this program as well as for those more permanently confined. In time, patients considered being on this plan a privilege, a token of improvement, and a terminal phase in hospitalization. We believe that this program has offered patients an essentially salutary experience.

We soon recognized that even so simple a manipulation of the patient's time brought forth complicated responses that carried strong dynamic implications. In each instance, the therapist and patient had to work through problems that involved anxieties and conflicts over the anticipated discharge from a completely protective environment, ambivalent feelings about termination or change in the doctor-patient relationship, conscious and unconscious motivations for work, and scrutiny of behavior in new situations and new interpersonal relationships. In many instances, the patients did their most constructive therapeutic work while on the Day Plan.

The multiple factors involved demand

careful evaluation and judgment in selecting patients suitable for this program. In our series of 19 patients, the problems and situations that obtained for selecting patients were essentially as follows:

(1) Problems of continuation of therapy at a time of conflict between complete dependence on the hospital and impulsive negation for any further need of treatment (5 patients).

(2) Problems of accepting patient's seemingly rational demands and conscious desire for work (3 patients).

(3) The needs for partial and time-limited rehabilitation by employment during early phases of recovery from acute psychotic episodes (3 patients).

(4) Short-time evaluation of patient's tolerance to stress in a nonhospital situation prior to discharge (5 patients).

(5) Gradual adaptation of chronic, psy-

chotic patients to home environments (3 patients).

The series of 19 patients on the Day or Night Plan is too small and too varied to allow us to draw specific conclusions of a statistical nature.

The report uses illustrations with case histories and comments on the more common problems observed, with particular elaboration on the significance of the plan as a terminal phase of hospital treatment.

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## NARCOTIC ADDICTS IN CHICAGO

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On April 2, 1951, a branch of the Municipal Court was established in Chicago to deal with those involved in narcotic charges. This is the first court in the United States hearing narcotic cases exclusively. The Honorable Gibson E. Gorman was assigned to this branch and has been sitting there continuously since its establishment.

On May 3, 1951, Chapter 38—192.23 of an act of the Criminal Code of the State of Illinois entitled "Uniform Narcotic Drug Act" was amended as follows:

SECTION 23. Whoever violates this act by selling, prescribing, administering or dispensing any Narcotic Drug, shall be imprisoned in the penitentiary for a term of not less than one year nor more than five years for the first offense.

Whoever violates this act by possessing, having under his control, manufacturing or compounding any Narcotic Drug shall be fined for the first offense not more than \$5,000.00, or be imprisoned for a period of not less than one year nor more than five years, or both. For any subsequent offense the violator shall be imprisoned in the penitentiary for any term from two years to life.

Whoever violates this act by selling, prescribing, administering, or dispensing any Narcotic Drug to any person under 21 years of age, shall be imprisoned in the penitentiary for any term from two years to life.

Whoever is authorized in this act to manufacture, possess, have under his control, sell, prescribe, administer, dispense or compound any Narcotic Drug, who violates this act by failing to comply with any provision prescribed in this act for the exercise of such authority, for the first offense shall be fined not more than \$1,000.00 or be imprisoned in the county jail for a term of not more than one year or both; and for any subsequent offense shall be fined not more than \$3,000.00 or be imprisoned in the penitentiary for a term of not more than five years, or both.

Any offense under this act shall be deemed a subsequent offense if the violator shall have been previously convicted of a felony under any law of the United States of America or of any state or territory, or of the District of Columbia relative to Narcotic Drugs.

SECTION II. Whereas the ominous and ever present problem of Narcotics has recently become acute

in many parts of the State, therefore an emergency exists and this act shall take effect upon its becoming a law.

Up to September 11, 1951, the number of cases<sup>3</sup> disposed of in the Narcotics Court was 6,518. Between April 1 and September 1, 1951, the House of Correction of the City of Chicago had received 1,104 inmates<sup>4</sup> from this court. During August 1951 there were 11 who were 17 years of age, 48 who were 18 to 20 years of age, 57 who were 21 to 25 years of age, and 24 who were 26 to 30 years of age. Figures were not available for racial origin.

On September 10, 1951, there were 378 drug addicts in the Cook County Jail, or 27.3% of the total jail population. These were 90% colored and 10% white; 88.3% were male and 11.7% female. Of the males 92% were colored and 8% white. Of the females 79.6% were colored and 20.4% were white. Of the males 82 were under 20 years of age, 182 were 21 to 27, 48 were 28 of 35 and 22 were over 35.

Most defendants are given fines, which in the event they are unable to pay are worked out at the House of Correction at the rate of \$1.50 per day on a state charge, and \$2.00 per day on a city charge. In case the addict is sent to the Cook County Jail, a Justice of the Peace may designate a rate of \$2.50 or \$5.00 a day to apply on a fine.

During the past 5 months we in the Behavior Clinic have seen a relatively large number of drug addicts. The Behavior Clinic is the psychiatric clinic of the Criminal Court of Cook County, and as a courtesy we also examine for the Municipal Courts housed in the Criminal Court Building.

<sup>3</sup> These cases will be reviewed by Dr. Harry R. Hoffman, Director of Mental Hygiene of the Chicago Board of Health.

<sup>4</sup>

|        |          |
|--------|----------|
| April  | .....351 |
| May    | .....166 |
| June   | .....157 |
| July   | .....265 |
| August | .....165 |

<sup>1</sup> Director, Behavior Clinic of the Criminal Court of Cook County, Chicago, Ill.

<sup>2</sup> Associate Director.

These cases have been referred to us mostly because of crimes ranging from drug addiction to armed robbery. The majority of those seen were in the 17 to 24 age group. However, older addicts have also been examined.

A series of 25 young addicts has been studied more exhaustively and a report on them will be published elsewhere. The drug of choice in all instances was heroin alone, or with cocaine, a "speed ball" as the mixture is called in the addict's parlance. All our subjects used the intravenous route of administration. In this series 96% of the cases were colored. They were not all sentenced because of drug addiction but, because of drug addiction, are segregated while serving their sentences for other offenses.

A brief sociological sketch demonstrated the majority to have rather low economic backgrounds. The family history for the most part was punctuated with unstable or absent parental figures. This is interpreted as providing a poor family situation to satisfy the need for a stable primary identification. The educational level was surprisingly good with the overwhelming majority having completed grammar school and a number having taken part in training beyond the high school level. Most of our group were able to continue their studies while addicted.

The personalities of the patients, with the exception of the 25 cases to be reported, were not studied in detail. However, it was evident that the management of hostile urges played a part in the need for oral satisfaction. Here we must note that, contrary to popularly accepted views, none of our patients gave a history of alcoholism or other manifestations of the need for satisfaction by intake means. This, true, may be influenced by the youthfulness of our subjects. However, even in those beyond 21 alcoholism was not evident during periods when the patients were not taking drugs. We feel the group-social aspect of addiction, which will be discussed, is responsible for this choice of satisfaction. Many of our patients were exhibitionistic in the description of achievements in sports, crime, or heterosexual activity. The over-all picture might be considered to be immature emotional re-

sponses, with difficulty in expressing hostility or aggression in a socially accepted manner.

The most striking impression gained is the group cultural aspects of addiction. Most of our patients came from a common geographical location. This location was within an area of predominately colored population. However, even within this area there was a rather uniform distribution of patients along commercial streets, and to a much lesser extent in residential and semi-residential areas.

The majority of our patients were members of a local social group in which drug addiction was almost universal. In addition, introduction of addiction was usually made by association with a group of people socially rather than by the usual manner of introduction by "pushers" or persons selling drugs. The groups in many instances were school groups, i.e., youngsters attending the same school and being introduced by school mates. We feel the fact that many are introduced by members in their own group accounts in part for the widespread incidence of addiction, as a group of youngsters can obviously make many more contacts than through "pushers" or persons handling drugs for a commercial purpose.

The primary purpose of patients' being referred to the Behavior Clinic is to determine mental competency to stand trial for a criminal act. Our experience indicates that the correlation between addiction and crime is very high: 86% were criminally involved because of the need to buy an ever-increasing supply of drugs.

Of the number of addicts seen, over half had experienced one or more withdrawals. Several had experienced as many as 4 or 5 withdrawals. Most of these withdrawals were a result of previous arrest and confinement. However, several of our patients had been withdrawn at Lexington, Ky.,<sup>5</sup> and several others had attempted to withdraw themselves. There seemed to be no common denominator as to the method of withdrawal and, needless to say, our patients were unable to adjust following withdrawal. Most of the patients stated that within a few days

<sup>5</sup> U. S. Government Hospital for treatment of drug addicts.



following return to their own neighborhood or community they were again taking drugs. Two remained off the drug for one month. All eventually returned to the drug.

In summary, our experience emphasizes the widespread incidence of addiction. The group-social aspect of taking drugs, and introduction by this means, we feel is partially responsible for the high incidence. The correlation between crime and addiction is, as expected, extremely high.

The need is evident for a program based on accepted medical withdrawal, with psy-

chiatric and social service consultation to aid in rehabilitation. Group therapy, such as Narcotics Anonymous, could be of assistance. Close follow-up and supervision would be essential in decreasing re-exposure to drugs.

In spite of the medical social aspects of the problem, from a practical point of view the most effective means of control is to concentrate on the source of the origin of the drug.<sup>6</sup>

<sup>6</sup> Up to December 21, 1951, the Narcotics Court has handled 9,158 cases.

## ACUTE DELIRIOUS MANIA

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AND

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States of rapidly evolving acute excitement with apparent delirium that in a high proportion of cases terminate in death, with no gross pathological findings postmortem, have been variously described since the first complete account was given by Bell(1) in the pages of this JOURNAL in 1849. Fodéré(2) in 1817 recognised the condition as an entity, but Bell's account remains the prototype in American and British psychiatry.

The illness is often described as Bell's mania, and it was suggested by Kraines(3) in his comprehensive review that conditions of this type should continue to be so called until their etiological basis had been more satisfactorily elucidated.

In continental psychiatry it is simply called *dé lire aigu*—acute delirium; but Marchand(4) describes a prognostically notorious "cryptogenic" form, which is perhaps nearer to what we understand by Bell's mania.

Other terms have been used in English, such as delirium grave, collapse delirium, exhaustion syndrome, and acute delirious mania. Stern(5) objects to the use of the word "mania" in describing the condition on the grounds that manic elements do not predominate and would substitute "acute confusional insanity." Whether we do so or not depends on whether we wish to use the term "mania" in the broad sense of excitement, or in its restricted sense as typifying the manic phase of manic-depressive psychosis. There is probably a great deal to be said for restricting the term "mania" to this sense, but the word "confusion" does not by any means bring out the fundamental characteristic of the condition, which is the extreme overactivity.

Whatever may be the relationship of the condition to other deliria and other acute psychoses, the illness as described by Bell is

well defined. The onset is acute, the excitement is extreme, the prognosis is grave, and the cause obscure.

The patient will get so little food, so little sleep, and be exercised with such constant anxiety and restlessness, that he will fall off from day to day. The emaciation goes on with a rapidity unexampled in cases of mania or fever or delirium tremens. At the expiration of two or three weeks, your patient will sink in death, diarrhoea occasionally supervening a few days previously.

On the other hand if the tendency is favourable, convalescence is established in about the same period, and the sufferer emerges in a state of absolute recovery at once, as he would do in the delirium of any acute disease. Nor are there any of the general consequences such as attend mania, as melancholy or impairment of mental integrity. I have had but few opportunities of making autopsic examinations, but the slight cerebral and meningeal engorgements which constituted the only marks of diseased change were not greater than the incidents of sleeplessness, agitation and death might be expected to leave, independent of any great morbid action behind these. These cases have delusions which are usually indefinite—confused—but partaking always of a distressful type. There is loathing of food, with suspicions of its being filthy or poisoned. Three-quarters at least terminated fatally.

Claude and Cuel(6), reporting on 3 fatal cases, record the same sort of picture:

Le syndrome "délire aigu" est essentiellement caractérisé par une confusion hallucinatoire éclatant brusquement et s'accompagnant d'agitation extrême, de fièvre, d'une atteinte grave et progressive de l'état général avec amaigrissement et sitiphibie. Il aboutit généralement à une mort rapide.

The following record describes a fulminating case, and allows a discussion of the etiological problems associated with this condition.

### CASE HISTORY

J. A., 46. Five days before admission to Cheadle Royal Hospital he complained of feeling unwell and began acting in a strange manner, cancelling orders essential for the conduct of his business. On admission he was stuporous, restless, resistive to examination, and answering questions in an indefinite way. He had periods of mutism and periods of rambling in which the same phrase was repeated

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over and over again—"It is all right, it will be all right." His tongue was furred and he would only take fluids with difficulty. Blood pressure, 170/90. By next morning his restlessness had greatly increased, and he was rambling in a fragmentary way. He appeared preoccupied with ideas of death, muttering "I am dead, I am dead" over and over again.

Sedation had little effect in controlling the condition and 2 days later he was in coma vigil, with eyes open and staring. Examination revealed equal but exaggerated tendon reflexes and bilateral flexor plantar responses. The pulse rate was 120. His face was suffused and pink in colour, but no rise of temperature was recorded by axilla, and the rectal temperature was 100°F. The right optic disc was pale and well defined; the left disc margin was obliterated and suffused, suggestive of an early papillitis. Pupils were equal and reacted fully to light. Slight neck rigidity was present. A lumbar puncture produced a clear fluid with a pressure of 150 mm. The protein was 25 mgms./100ml., and the cells less than 5 per cu. mm. The Lange colloidal gold reaction gave a negative curve, and the Wassermann reaction was negative in the blood and c.s.f.

A few hours afterwards the coma deepened and his temperature rose to 102°F. Three hours later he died.

A post-mortem examination (for which we are indebted to Dr. Rupert Sykes) was carried out. The body was that of a well-developed man that, apart from engorgement of the cerebral vessels and dilatation of the heart, showed little evidence of gross disease.

#### DISCUSSION

The pathological histology and pathological biochemistry of acute delirium and other acute psychoses have recently been more intimately examined, notably by Larson(7), Morgan(8), Yde(9), and Hermann and Lund(10).

Larson found 52% of deaths in the course of manic-depressive illness could be related to the onset of acute delirious mania. There was an equal sex distribution and 50% of the cases were below 35 years of age. He does not relate the acute delirious syndrome unequivocally to manic-depressive psychosis, but states it also appears in schizophrenics. In his analysis of 14 fatal cases, he comments on the low blood pressure, low blood chlorides, slightly elevated blood urea nitrogen, albuminuria, low chloride excretion, circulatory collapse, and the appearance of terminal neurological signs, such as muscular twitchings, spasms, and bizarre paralyzes.

Pathologically, the most noteworthy feature was the presence of petechial haemorrhages of recent origin, perivascular in dis-

tribution, localised to, but widely scattered throughout, the midbrain and hypothalamic region.

He relates the physical symptoms, laboratory, and post-mortem findings to other conditions, such as heat-stroke, where hypochloraemia is a common factor. In acute delirious mania, the hypochloraemia and dehydration are due to loss of chloride and fluid by sweating, the result of the psychomotor activity and difficulty of replacement due to diminished fluid and chloride intake. The petechial haemorrhages are the consequence of loss of chloride from the intercellular substance of the capillary endothelium. He reports improvement in those cases treated with hypertonic saline. He is careful to point out, however, that the *initial* factor in the onset of the illness is a mental one, in which the patient becomes irritable, disturbed, sleepless, and finally wildly delirious.

This is a fine paper that deserves close study, as it is the most complete attempt so far made to study the cause of death in acute psychoses by full laboratory and pathological techniques. It represents a welcome change from those investigations aimed at relating the cause of acute delirious mania to obscure toxic and infective factors. It would seem in general that such investigators have been unduly impressed by the similarity of the clinical picture to those deliria occurring in the course of infective processes, and have been led to identify scanty cellular changes in the brain with those of encephalitis. Such attempts have never been conspicuously successful and have usually involved invoking other factors to maintain a satisfactory explanation.

Thus Claude and Cuel, describing the pathological features in their 3 fatal cases, note that they seem to show "*une atteinte brusque et violente de la substance nerveuse par un processus d'ordre infectieux ou toxique, processus qui semble frapper électivement l'axe cérébro-spinal.*" They add, however:

*L'existence d'un choc émotionnel récent est souvent relevé dans les anamnestiques des délirants aigus. Sans doute ce choc émotionnel expliquerait difficilement à lui seul l'éclosion d'un syndrome morbide dont la nature toxi-infectieuse est si vraisemblable. On peut admettre qu'il est susceptible d'exer-*

cer une sorte d'action sensibilisatrice qui préparerait une rupture de l'équilibre dynamique des éléments nerveux, sous l'influence d'une agression extérieure, d'ordre toxique ou infectieux.

Larson's account leaves several problems unsolved. He explains the concentration of haemorrhages in the midbrain by the fact that this area forms a "locus minoris resistentiae." This does not seem a very satisfactory explanation why these petechial haemorrhages should be concentrated in this area, and other areas of the brain (*e. g.*, the cortex) relatively escape, although there is no evidence that the capillary endothelium in these areas is any less loaded with chloride than that of the midbrain. While the mechanisms described by Larson are adequate to explain the cause of death in acute delirious mania—*i. e.*, they describe the natural physiological and pathological sequelae that follow the persistence of the psychomotor activity—they do not explain the nature of the actual process involved in the onset of the condition. Why do a proportion of cases spontaneously recover (25% according to Bell)? Presumably, on Larson's explanation, this is due to the cessation of the mechanism producing the psychomotor activity, before the effect of the hypochloraemia and dehydration have time to produce death.

It should be added that other observers have failed to confirm Larson's finding of hypochloraemia. Yde confirms a fairly constant azotaemia, but in his 12 cases he records only normal or slightly decreased blood chlorine values.

Hermann and Lund describe changes in blood pyruvic and citric acid but, while admitting they are not specific to acute delirium, feel they are of importance in the course of the disorder. Such changes are more likely to be secondary to the great muscular and metabolic overactivity.

Bom(11) describes a case of acute delirium following sulphonamide-treated erysipelas. Apart from a pituitary lesion (an intrasellar cyst, undoubtedly incidental), the pathological picture was similar to that described by Larson, with minute perivascular haemorrhages in the hypothalamus and surrounding brain-stem region. In addition, acute ganglion cell changes were found in this area, similar to those described by Mor-

gan. Bom criticises Morgan's conclusion that there is an elective hypothalamic lesion, as Morgan did not examine the remaining part of the cerebrum in his material. He admits, however, that in a study of 17 (unpublished) cases dying of acute delirium, which he himself examined, although acute ganglionic changes were found throughout the brain they predominated in the hypothalamic region.

We have described the pathological changes at length because we believe it possible to see certain definite trends in the study of this material. Most observers agree that the brunt of the reaction is borne by the hypothalamus and surrounding brain-stem region, and this reaction expresses itself in the form of perivascular petechial haemorrhages and acute ganglionic changes.

Morgan believes the essential change is a hypothalamic dysfunction, due to direct injury or following an indirect lesion, due to endogenous or exogenous toxins, endocrine disturbance, etc. This dysfunction results in defective autonomic and emotional correlation, which is either sufficient to release a psychosis or forms a point of weakness through which psychic traumata, organic disorders, or toxic conditions may provoke psychic disturbances. This explanation is too hypothetically involved to warrant much credence and gives too dominant a role to the hypothalamus, in initiating the condition.

Masserman (12) has shown that hypothalamic stimulation in cats was unaccompanied by "meaningful subjective experience." The cat would purr and continue to lap milk, despite the appearance of "sham rage."

Recently, Byrne(13) has described the case of a child who, among other disturbances of hypothalamic function following upon a head injury, showed periodic attacks of psychomotor restlessness. The child was unable to keep still or concentrate for any length of time. Although normally well adjusted, during these periods he was easily angered and this led to aggressive behaviour. It is interesting to note that Byrne comments, "He admits to the usual anticipatory anxiety before school examinations and the like, but the external expressions of his mood appear to be exaggerated out of all proportion to

*the depth of feeling tone with which they are associated."*

We would emphasise Masserman's conclusions on the role of the hypothalamus in emotion:

It would seem safest to assign to the hypothalamus its experimentally demonstrable role in reinforcing and co-ordinating the neural and hormonal mechanisms of conative and emotional expression and reserving for more adequate proof the hypothesis that it is either the dynamic source or seat of experience of affective states. Much experimental, psychological and clinical evidence clearly indicates that emotion is a highly integrated conative, cognitive and affective-somatic reaction in which not only the central nervous system but the entire organism functions as a psychobiologic whole in its sensitive adaptations to the continually changing organismal milieu.

On the basis of these conclusions, we should like to put forward our own conception of the nature of this disorder.

We believe the condition as described by Bell is essentially an affective disorder, which bears a closer relation to the acute agitated depressive state than to the manic phase of manic-depressive psychosis. We do not regard this belief as inconsistent with any of the findings described above, which are regarded as secondary. They are in other words the result of the extreme overactivity. That much of this overactivity is likely to be hypothalamic in expression seems to us self-evident, in view of what we know of the role of the hypothalamus in the physiology of emotion.

Whether death is due to exhaustion of the hypothalamic and midbrain centres, producing the "shock" syndrome, which the terminal stages of this condition so closely resemble, or is due to a form of "heat stroke" dependent on the dehydration and hypochloreaemia, we are unable to determine. In general, we incline to the view that the most likely cause of death is hypothalamic and midbrain centre exhaustion, following upon induced overactivity in this region, which is cortically determined, *i. e.*, determined by the psychosis, not producing it. This appears to us a better explanation than one that regards the psychosis as being "released" hypothalamically (Morgan).

In truth, both factors of heat apoplexy and hypothalamic exhaustion may play their

part, and it can be seen how in combination they would produce a vicious spiral, leading to the highly dangerous situation characteristic of this malignant form of psychosis. A study of our own case has convinced us that we were dealing with a hyperacute affective reaction, closely akin to a fulminating agitated depressive state. And this seemed to be borne out by our analysis of the clinical features of the cases described in the literature we have quoted (3, 6, 10, 11).

We do not wish to discuss this at length, but would draw attention to the following features. The onset of the condition is usually acute and can be traced back only to a few days before admission to hospital. In one of the cases described by Hermann and Lund, however, the patient was convalescing from a depressive reaction with weeping and anxiety and periods of restlessness and religious obsessions, which appeared to be subsiding before the hyperacute phase came on. There may, however, be a precedent period of worry or a history of recent emotional shock. This was noted in 2 of the cases described by Hermann and Lund and also in the case described by Kraines. In our own case, the patient had suffered a prolonged period of marital upset and immediately prior to the onset of the condition his wife had left him.

In all, restlessness, anxiety, loss of power of concentration, and irrationality of action rapidly increase over a few days, leading to a state of great overactivity.

In Bom's case the condition appeared to arise directly out of the treatment of an infective process, treatment that seemed to have the process well under control. Bom minimises the psychogenic factors in his patient, although she showed "a great fear of infection on admission to a hospital for infectious disease when poliomyelitis was rife." The onset of the psychosis was characterised by the patient's becoming "silent, introspective, speaking sometimes inadequately, at other times of infection." We would point out in this context that infective processes are notorious in precipitating depressive reactions, *e. g.*, the frequency with which a history of influenza is found occurring before the onset of cases of melancholia.

In certain cases of acute delirious mania,



a previous attack of manic-depressive illness is recorded. In Claude and Cuel's series, one of the patients had been in a mental hospital for a period of 6 months with a melancholic illness from which she had apparently recovered, only to break down 6 months after her discharge with the attack of acute delirium that caused her death.

In our own case the patient was reputed to have had a "strained" heart at the age of 18, since when he had been somewhat hypochondriacal. We regard this as highly suspect, especially as at post-mortem the heart was in excellent condition and the aorta virtually free from atheroma. It is more likely to indicate a previous anxiety reaction in which the somatic components obscured the psychological ones. His personality too was restricted and he had few friends and few interests.

A study of the affect in these cases shows that it is almost always described as depressive, with great anxiety and perplexity. The delusional content is predominantly persecutory or self-accusatory, often with ideas of influence or reference of a religious kind. It can be seen how such a picture could lead to the condition's being classified as an acute schizophrenic reaction. Indeed Bleuler (14) includes certain examples of this type of psychosis with his schizophrenic group. One of us (15) in a previous communication has attempted to show that such atypical features are not uncharacteristic of other forms of depressive reaction, where overactivity may not be prominent.

The physiological mechanisms underlying this psychosis should not be regarded as specific to it, although they are most likely to be induced by the type of affective reaction that we believe to be that originally described by Bell.

Catatonic excitement, arising in a schizophrenic, could conceivably lead to exhaustion and the biochemical effects described above. Generally speaking, however, such episodes are short-lived, and show none of the prodromal features that have been noted in acute delirious mania.

The same could apply to a hyperacute mania, of the manic-depressive type, and indeed in many cases manic elements have been described in the clinical picture of acute de-

lirious mania. They are, however, not sustained, although they may reappear, but in general they do not predominate. It would seem strange if in such a fulminating reaction, involving as it does such extreme overactivity of both brain and body, various elements did not appear. We would emphasise that in general the affect is depressive, the overactivity is rather of the extreme agitation than manic push and pressure, while the delusional content is persecutory or self-accusatory. We would add that in our own case manic elements were not noted.

With due temerity we should like to suggest that, if the depressive basis of the condition is accepted, the rational treatment is electric convulsive therapy, which should be given early, before the effects of exhaustion have weakened the patient to the point when the giving of such treatment would constitute an entirely unjustifiable risk. In the later stages, it would seem that treatment on the lines indicated by Larson with replacement of fluid and salt and adequate sedation should be followed.

#### SUMMARY

1. A case of acute delirious mania (Bell's mania) is described.
2. It is regarded as an affective reaction with greater affinity to the fulminating agitated depressive state than to the manic phase of manic-depressive psychosis.
3. The underlying physio-pathological mechanisms that lead to death in this malignant form of psychosis are discussed.
4. The administration of electric convulsive therapy in the *early* stages of the illness is advocated.

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## THE PSYCHOLOGICAL DIFFERENTIATION OF ORGANIC BRAIN LESIONS AND THEIR LOCALIZATION BY MEANS OF THE RORSCHACH TEST<sup>1</sup>

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The Rorschach test has been employed in investigation of a wide variety of organic disorders such as senile dementia(1), post-encephalitic Parkinsonism(2-4), brain tumor(5), subdural hematoma(6), postconcussion syndrome(7, 8), Pick's disease(9), epilepsy(10-13) and mental deficiency(14-16). While these studies generally offer descriptions of the personalities of patients suffering from such conditions and the consequent impairments it is striking to note their many similarities. It is perhaps from lack of readily defined Rorschach signs that would reliably and consistently serve to distinguish these different organic disorders that a trend to generalization has occurred, at least insofar as this test method of investigation is concerned. Thus, Piotrowski(17, 18) in distinguishing 10 organic Rorschach signs and Ross(19, 20) in developing a "disability" scale considered the various lesions as one.

Experience with these ratings revealed to the authors that their capacity to screen for organic brain damage varied considerably according to whether the lesion was diffuse or localized and, further, according to the specific localization of the lesion(21). Review of the individual items comprising these scales revealed that more than half were definitions of positive expected psychopathological expression such as perseveration, perplexity, impotence, and automatic phrasing. Rather than attempt a redefinition of these items to improve the validity of this procedure, as Hughes has attempted(22), it seemed more appropriate to attempt a definition of those test features *not* commonly found in such cases. Rather than attempt to infer an organic impairment from the presence of certain types of response, organic

brain damage may be described in terms of deficit.

A set of 7 Rorschach signs with quantitative evaluation was determined: Absence of these signs lends probable indication of an organic impairment while their presence (to a specified degree) serves to exclude the diagnosis of organic defect. Specifically the signs are as follows:

1. The number of human movement plus the number of inanimate movement responses being greater than 2 ( $M + m > 2$ ).<sup>2</sup>
2. The presence of any diffuse shading responses ( $k + K + FK > 0$ ).
3. The number of texture-shading responses plus the number of form-color responses being greater than 2 ( $Fc + FC > 2$ ).
4. The total number of responses to the test being greater than 20 ( $R > 20$ ).
5. The presence of space responses ( $S > 0$ ) (with one exception of inside S, At, VIII, central position, top  $\frac{1}{3}$ ).
6. The total form level(24) of all responses given being greater than plus 20 (Total Form Level  $> +20.0$ ).
7. The proportion of good original responses being greater than 15% of the total number of responses given ( $O + \% > 15$ ).

Generally accepted principles of Rorschach interpretation would consider these signs to lend an indication of such features as creativity, conflict, anxiety, sensitivity, emotional rapport, productivity, perceptual reversal of figure-ground relationships, quality of response and originality, respectively. The absence of these signs may offer a test description of many of the well-established clinical features of organic defect.

Therefore, an investigation was undertaken to determine to what extent these signs would be found in organic disorders, particularly when compared with their frequency of occurrence among other psychiatric conditions of "functional" origin and among normal subjects.

<sup>1</sup> Read at the 107th annual meeting of The American Psychiatric Association, Cincinnati, Ohio, May 7-11, 1951.

From the Verdun Protestant Hospital, Montreal.

<sup>2</sup> A more extensive description of the scoring procedure and interpretation of these scoring symbols is offered by Klopfer and Kelley(23).

The set of 7 signs has been applied to 4 separate groups of patients with known localized brain lesion and to 2 groups of patients with diffuse lesion. Control groups of schizophrenics, manic-depressives, psychoneurotics, and superior and average "normals" have served to illustrate the screening capacity of the signs. The percent of occurrence of the separate signs (see Table 1) by diagnostic category demonstrates that each sign occurred significantly less often among the organic conditions investigated. Thus,

of 0-2 serve as probable indication of an organic impairment while those yielding scores of 3-10 serve to "exclude" the diagnosis of organic defect. Of the organic cases thus evaluated, a total of 92.9% obtained a deficit rating, while of the nonorganic groups it was possible to exclude the existence of organic impairment in 83.3% of these cases. But 16.6% of nonorganic cases obtained a deficit rating and, as these were in the majority deteriorated schizophrenics, the possibility of an actual organic impairment is

TABLE 1  
PERCENT OCCURRENCE OF DEFICIT SIGNS BY DIAGNOSTIC CATEGORY

|                                | N  | M + + + | K + K + PK > 0 | Fc + FC > 2 | R > 20 | S > 0 (except viii) | Form Level > + 20.0 | Si > 0 + 0 |
|--------------------------------|----|---------|----------------|-------------|--------|---------------------|---------------------|------------|
| Cortical .....                 | 10 | 10      | 10             | 20          | ..     | ..                  | ..                  | 20         |
| Extrapyramidal hyperkinetic..  | 10 | ..      | ..             | 10          | ..     | 10                  | ..                  | 10         |
| Diencephalic .....             | 10 | ..      | 20             | ..          | ..     | ..                  | ..                  | ..         |
| Extrapyramidal akinetic.....   | 10 | 10      | 10             | 10          | ..     | ..                  | 20                  | 10         |
| Diffuse organic (nonsenile)... | 10 | 10      | 30             | 30          | ..     | 10                  | 10                  | 20         |
| Senile dementia.....           | 20 | ..      | 15             | 30          | 20     | 5                   | 5                   | 5          |
| Schizophrenia .....            | 20 | 25      | 65             | 30          | 40     | 35                  | 35                  | 45         |
| Manic-depressive .....         | 10 | 50      | 20             | 40          | 70     | 40                  | 90                  | 40         |
| Psychoneurosis .....           | 10 | 70      | 60             | 50          | 20     | 20                  | 50                  | 90         |
| Normal-superior .....          | 10 | 100     | 80             | 90          | 90     | 30                  | 100                 | 100        |
| Normal-average .....           | 10 | 50      | 50             | 70          | 60     | 20                  | 90                  | 80         |
| Organic .....                  | 70 | 4.3     | 14.3           | 18.6        | 5.7    | 4.3                 | 5.7                 | 10.0       |
| Nonorganic .....               | 60 | 53.3    | 56.7           | 51.7        | 53.7   | 30.0                | 66.7                | 66.7       |
| Score weight of sign.....      | .. | 2       | 1              | 1           | 2      | 1                   | 2                   | 1          |

Organic  
Non-organic

from the absence of these signs may be derived an "organic deficit rating."

Where the ratio of occurrence of each individual sign was approximately 1:5 between organic: nonorganic states a score of 1 was ascribed to the particular sign. Where this ratio reached a level of approximately 1:10, a score of 2 was ascribed. Since 3 of the signs came to be double-weighted, that is, scored as 2, a total possible score of 10 was derived from the signs.

On the basis of the frequency distribution of the total scores obtained in the various organic and nonorganic categories investigated (see Table 2) it was possible to establish a cut-off point at between score 2 and 3. That is to say, Rorschach records yielding a score

still open to speculation.<sup>8</sup> Of the total organic group of 70 cases, only 5 yielded "false negative" scores; that is to say, in only 7.1% was the existence of an organic defect "excluded" by the score. It is reassuring that even in these 5 cases there is corroboration that they were relatively well preserved. Two were cases of G.P.I., tested following malarial therapy and found to have an above average intelligence (IQ above 110). Another was a case of Parkinsonism of recent onset (7 months) with the tremor involving only the right arm. This subject had been hospitalized for several years prior to the

<sup>8</sup> Recent biochemical investigation has established the existence of certain similarities between deteriorated schizophrenics and organic psychoses (25).

development of neurological symptoms with a commitment diagnosis of involutional melancholia. His intelligence was near superior (IQ 117). The remaining 2 cases while diagnosed as senile dementia, paranoid type, did not reveal any marked intellectual defect according to the Wechsler-Bellevue Adult Intelligence Scale (26). One was even a "worker" in the hospital mending room.

As a means of improving further the discriminatory power of the "organic deficit rating," several additional test features may be outlined. The more schizophrenics are deteriorated, the more liable are their Rorschach records to show a deficit rating. However, such subjects generally display marked

certain cases of brain lesion, particularly cases of Parkinsonism, such subjects will generally demonstrate sign of deficit on the Rorschach test. Thus, while intellectual limitations bear a decided influence on the "organic deficit rating," they are not of such basic nature in regard to this technique as defects of the personality structure.

Mention has been previously made of Piotrowski's 10 "organic signs" and Ross' "disability" scale. It seems interesting to compare their effectiveness with the present "organic deficit rating." The criterion level of these ratings is as follows: when Ross' disability scale reaches a score of 11 an organic impairment is indicated, scores of less

TABLE 2  
FREQUENCY DISTRIBUTION OF "ORGANIC DEFICIT RATING"

| Score | Cortical | Extrapramidal hyperkinetic | Diencephalic | Extrapramidal akinetic | Diffuse organic (non-senile) | Senile dementia | Schizophrenia | Manic-depressive | Psychoneurosis | Normal-superior | Normal-average | % Organic | % Nonorganic |
|-------|----------|----------------------------|--------------|------------------------|------------------------------|-----------------|---------------|------------------|----------------|-----------------|----------------|-----------|--------------|
| 0     | 5        | 7                          | 8            | 6                      | 4                            | 11              | 2             | 1                | ..             | ..              | 41             | 3         | 58.6         |
| 1     | 3        | 3                          | 2            | 2                      | 3                            | 4               | 5             | ..               | ..             | ..              | 17             | 5         | 24.3         |
| 2     | 2        | ..                         | ..           | 1                      | 1                            | 3               | 1             | ..               | ..             | ..              | 1              | 7         | 10.0         |
| 3     | ..       | ..                         | ..           | ..                     | 1                            | ..              | 4             | 1                | 3              | ..              | 1              | 8         | 1.4          |
| 4     | ..       | ..                         | ..           | ..                     | ..                           | ..              | ..            | 2                | ..             | ..              | 1              | ..        | 3            |
| 5     | ..       | ..                         | ..           | 1                      | 1                            | 1               | 1             | 1                | 2              | ..              | 2              | 3         | 6            |
| 6     | ..       | ..                         | ..           | ..                     | ..                           | 1               | 2             | 3                | 1              | 1               | 2              | 1         | 9            |
| 7     | ..       | ..                         | ..           | ..                     | ..                           | ..              | 3             | 3                | 1              | ..              | 2              | ..        | 9            |
| 8     | ..       | ..                         | ..           | ..                     | ..                           | ..              | 1             | ..               | ..             | 2               | ..             | ..        | 3            |
| 9     | ..       | ..                         | ..           | ..                     | ..                           | ..              | ..            | 1                | ..             | 4               | ..             | ..        | 5            |
| 10    | ..       | ..                         | ..           | ..                     | ..                           | ..              | 1             | ..               | 1              | 3               | 2              | ..        | 7            |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | % Organic | % Nonorganic |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 58.6      | 5.0          |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 24.3      | 8.3          |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 10.0      | 3.3          |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 1.4       | 13.3         |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 3         | 5.0          |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 6         | 10.0         |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 9         | 15.0         |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 9         | 15.0         |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 3         | 5.0          |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 5         | 8.3          |
|       |          |                            |              |                        |                              |                 |               |                  |                |                 |                | 7         | 11.7         |

qualitative deviations (23, ch. 14) such as frankly bizarre responses in contrast to the poor but usually simple responses of the organic. Some cases of depression may well show deficit ratings, particularly as their retardation is more severe, but here the consequent prolonged reaction times generally serve to distinguish these subjects from the majority of cases with organic brain damage (exception, Parkinsonism, see below, (21)). In addition, where the intellectual capacity of the subjects evaluated becomes of lower order, deficit signs will be more apparent. This rating is, admittedly, sensitive to limitations of intelligence as well as impairments of intelligence. However, it has been found that while no intellectual impairment may be apparent through use of an intelligence test in

than 10 are of indefinite significance, though the lower they are, the more assurance is given that an organic impairment is not present. Piotrowski has reported that when 5 or more of his signs are present in a record it is very probable indication of intracranial organic pathology. Scores of 4 or less are of indefinite significance. Conclusions reached by the present investigation suggest that when the "organic deficit rating" is less than 3, there is probable indication of an organic impairment whereas scores of 3 or more serve to exclude the test diagnosis of organic defect.

Comparison of these 3 approaches through application to the Rorschach records obtained from different groups of organic and nonorganic subjects shows that all follow the



"expected" trend in the nonorganic cases to an essentially similar degree (see Table 3). Specifically, for approximately 80% of nonorganic subjects, the rating is nonorganic. The bulk of the exceptions in all 3 approaches is contributed by the schizophrenics, particularly the deteriorated schizophrenics. When the 3 sign approaches were applied to cases with organic brain damage, for which they were designed, significant differences were found. The "organic deficit

rating" more frequently provides valid indication of organic brain damage and, when greater than a score of 2, serves to exclude reliably the (test) diagnosis of organic impairment.

Perusal of the Rorschach literature illustrates that, while organic disorders have been studied extensively according to disease entities such as epilepsy, senile dementia, and brain tumor, etc., few reports have been made of attempts to distinguish the influence of the specific localization of the brain lesion (15, 27). Our initial attempts to define differences in the Rorschach responses dependent on the localization of brain lesion were highly encouraging (28) and we have now extended the investigation (21) to a consideration of 4 groups of brain lesions of various localization (see Fig. 1), as follows: (1) cases with lesion of the cortex and/or adjacent white matter, (2) cases with significant diencephalic involvement, (3) cases with extrapyramidal hyperkinesia, indicating lesion of the striate body, and (4) cases with extrapyramidal akinesia (Parkinsonism), indicating lesion of the pallidum-nigra system. The necessity of brevity will not permit a discussion *in extenso* of these findings at the present time. A few of the more outstanding deviations dependent on each particular localization of lesion studied will be outlined.

In general terms, it seems possible to state that the variations of Rorschach response among these 4 groups of localized lesion suggests the existence of 2 distinguishable cerebral systems. Responses given by patients with diencephalic and/or extrapyramidal akinesic lesions display signs to indicate that there may be an overlapping of involvement while, similarly, the cortical and extrapyramidal hyperkinetic groups show a certain interrelationship. Interestingly, it is from the color responses, responses said to reflect the potential capacity of the subject for emotional or affective expression, that the major key to this distinction is provided.

Patients who neurologically show signs of significant involvement of the diencephalon have been reported to give no color response to the Rorschach test (28). As this includes the achromatic as well as the chromatic color responses we have indication that this lesion

TABLE 3  
% OF DIAGNOSTIC CATEGORY FOLLOWING  
"EXPECTED" TREND

|                       | N  | Dörken-Kral "deficit rating"<br>(organic 0-2; nonorganic<br>3-10) | Piotrowski's signs (organic<br>5-10; nonorganic 0-4) | Ross' disability scale (organic<br>11-15; nonorganic 0-10) |             |
|-----------------------|----|---|--|--|-------------|
| Cortical .....        | 10 | 100   | 50   | 70   | Organic     |
| Extrapyramidal        |    |   |  |  |             |
| hyperkinetic .....    | 10 | 100   | 60   | 100  |             |
| Diencephalic .....    | 10 | 100   | 80   | 90   |             |
| Extrapyramidal        |    |   |  |  |             |
| akinetetic .....      | 10 | 90  | 10   | 30   | Non-organic |
| Diffuse organic       |    |   |  |  |             |
| (nonsenile) .....     | 10 | 80  | 50   | 70   |             |
| Senile dementia ..... | 20 | 90  | 50   | 80   |             |
| Schizophrenia .....   | 20 | 60  | 50   | 55   |             |
| Manic-depressive ..   | 10 | 90  | 80   | 60   |             |
| Psychoneurosis ....   | 10 | 100   | 100  | 90   |             |
| Normal-superior ...   | 10 | 100   | 100  | 100  |             |
| Normal-average ...    | 10 | 90  | 100  | 90   |             |
| Organic .....         | 70 | 92.9  | 50.0   | 74.3   |             |
| Nonorganic .....      | 60 | 83.3  | 80.0   | 76.7   |             |

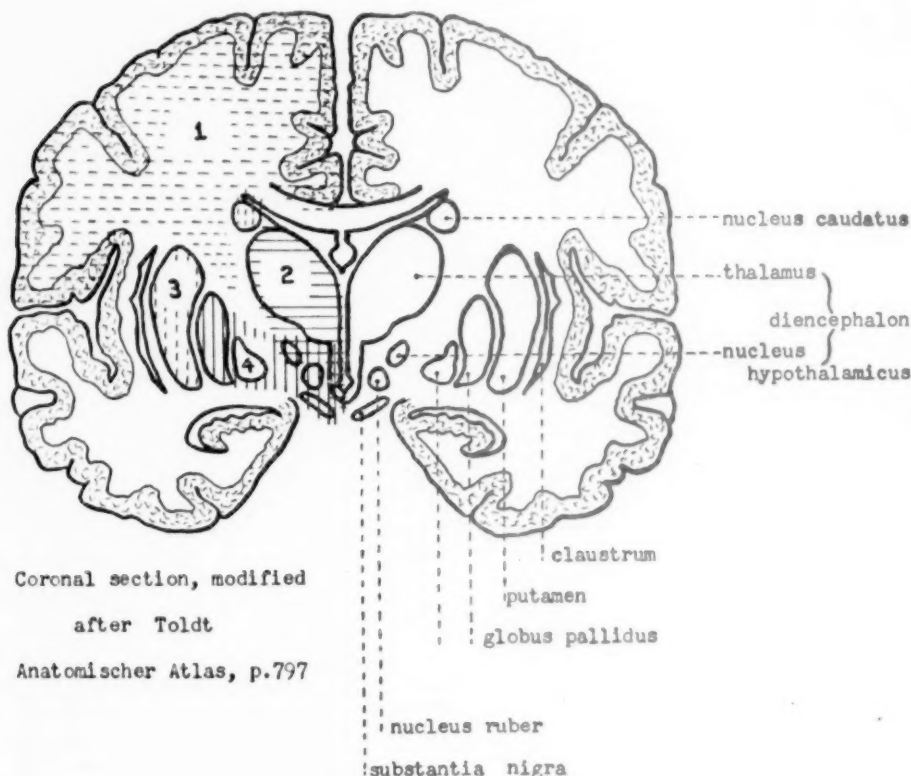
rating" followed the "expected" trend in approximately 93% of the organic subjects, whereas Ross' disability scale was nearly 75% effective and Piotrowski's signs were "positive" in but 50% of these cases. Piotrowski's criterion of organic impairment was reached in only 50% of both groups of diffuse lesions and in the group with localization of the lesion in cortical areas. Among subjects with Parkinsonism, only 10% showed a positive rating. Ross' disability scale was also decidedly weak in screening for organic impairment among the group of Parkinsonians. Thus, it would ap-

produces a distinct disturbance of emotionality. The affective potentials of both elation and depression appear to suffer some type of destruction, at least insofar as the capacity to perceive the emotional component of colors is concerned.

Color response may also be absent in certain cases of Parkinsonism and, when ab-

action time reflecting their well-known bradyphrenia.

A further interesting point regarding the Parkinsonian group should be mentioned. Just as "pseudoneurotic" features have been observed clinically (29-31), so too they can often be found in the Rorschach records of these patients (3, 21). In addition, Ross'



Coronal section, modified  
after Toldt  
Anatomischer Atlas, p.797

FIG. 1.—Levels of Brain Lesions.

1. Cortical and subcortical.
2. Diencephalic.

3. Extrapyramidal hyperkinetic type.
4. Extrapyramidal akinetic type.

sent, suggests an extension of the pathological process to the diencephalon. This has apparently been the case in all our subjects who suffered the acute stage of their encephalitis in childhood or adolescence regardless of the extent of their intellectual preservation (21). In contrast to the majority of organic cases with localized brain lesion, those with Parkinsonism frequently display a long re-

ratio is usually heavily weighted to the instability (neurotic) rather than the disability (organic) scale. Nonetheless, the "organic deficit rating" generally shows a score of less than 3, thus indicating an organic impairment by means of the Rorschach test.

In contrast to the 2 groups mentioned, it was found that all patients with cortical lesion gave color response though often of

a crude variety. Where the localized cortical lesion has resulted in defective intelligence, color naming (Cn) is common. Interestingly, color naming and, in fact, all types of color responses were surprisingly rare among cases of senile dementia(1). This would tend to provide corroborative psychological information to the observation that the underlying organic processes in senile dementia extend beyond the regions of the cortex, a fact reported by Papez and Bateman(32). Werner(16) in his investigation of brain-injured and familial mentally defective children found that the brain-injured gave nearly 3 times more color responses and that these were predominantly of the pure color variety. While it is usual for organic patients to show a poverty in range of thought content, or stereotypy, many patients with localized cortical lesion do not. Here, the thought content may well be varied though there is test evidence of a lack of adequate control over the thought processes.

Patients with extrapyramidal hyperkinetic lesions follow suit with those of localized cortical lesion insofar as their color response is concerned. However, the reaction time of the hyperkinetic subject is unusually rapid (21). This may well be dependent on interruption of a cortico-striate circuit(33) resulting in a faster tempo of response in addition to the hyperkinetic movements.

It seems advisable, at this point, to introduce a note of caution. Though the aforementioned differences were found to occur with brain lesions of particular localization this is *not* intended to imply that solely from the presence of these deviations in a Rorschach record may the existence of specific localized brain lesions be inferred. Certainly at this stage of the investigation, this would be pushing the findings beyond reasonable conclusions. For example, absent color response may well occur with depression(34, 35); a wide range of thought content is typical in hypomania or mania(36); and color naming is frequent in schizophrenia (37, 38), particularly of the hebephrenic type(39). Thus as might be logically expected, the factors of personality that can be evaluated by the Rorschach test vary on the basis of psychogenic and functional as well as organic differences in the individual

personality structure. However, when applied with caution, the test differences as found among the localizations of brain lesion studied may be of value especially when the "organic deficit rating" indicates the presence of an organic impairment.

In summary, on the basis of a psychological investigation of 4 different groups of cases with localized brain lesion and 2 groups of patients with diffuse brain lesion (total of 70 subjects) in comparison with control groups of schizophrenics, manic-depressives, psychoneurotics, and "normals," an "organic deficit rating" composed of 7 Rorschach signs has been described. This approach appears to provide a reliable test distinction of organic impairment and is consistent with the psychiatric description of the consequences of organic brain damage in terms of deficit. Response to the Rorschach test was also seen to vary in accordance with the localization of brain lesion.

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## BEHAVIORAL PATTERNS IN EARLY MEETINGS OF THERAPEUTIC GROUPS<sup>1</sup>

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### I. Introduction.

The behavior of the patient in the psychotherapeutic situation offers important guides to the long-term strategy and the day-to-day tactics of psychotherapy. Therapeutic interventions are guided both by superficial aspects of the patient's behavior and by its meaning in terms of his underlying difficulties. The therapist's handling of a patient's obsequiousness, aggressiveness, taciturnity, or volubility, for example, is influenced partly by the behavior itself, but more basically by the therapist's understanding of what issues and concerns in the patient's life it reflects.

A patient's behavior in a therapeutic group may pose practical problems with respect to other group members as well as the patient himself. The therapist's intervention must be planned with consideration of its effect on the whole group. For example, a hostilely silent patient may dampen an entire group, and unskillful efforts to draw him out may intimidate other patients who are too shy to speak. A monopolist may likewise disrupt group functioning, but the therapist may have to resist the temptation to squelch him lest other patients take this as a sign that he will rebuff them also. Even an apparently useful pattern of behavior, such as free presentation of one's personal problems, may present a problem in group treatment, as with those patients who compulsively reveal too much of their difficulties too soon and then feel so ashamed that they leave therapy.

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Besides presenting problems in immediate management, patients' behavior in therapeutic groups often seemed to express some of their major difficulties in interpersonal functioning. This is to be expected since the group resembles real life situations in many ways, while rewarding or accepting expressions of attitudes that must be concealed in ordinary social situations. We have been struck by the consistency of behavioral patterns of certain patients and by the fact that the same patterns tended to appear in different groups, differently composed, and conducted by different doctors, suggesting that such patterns express deep-seated personality trends rather than transient responses to a particular group situation.<sup>2</sup> Furthermore, many of these behavior patterns seemed to create the same kind of difficulties for the patient in the group that they reported with members of their families and other persons in their daily lives. As these patients improved clinically and began to get along more successfully with family and friends, their behavior patterns in the group showed corresponding changes.

These considerations pointed to the desirability and feasibility of systematically describing and, it is hoped, eventually classifying patterns of behavior shown by patients in the group, as a guide to therapy. Such descriptions are particularly needed, since the standard diagnostic classification of neuroses, being essentially in terms of symptoms, offers very little aid in this respect. We therefore decided to try to identify and describe such patterns as related to patients' personality attributes and psychodynamics

<sup>2</sup> Behavior similar to that of the second pattern in this paper has been described by W. R. Bion(1) and Alexander Wolf(5), whose ways of conducting groups differ markedly from each other and from ours.



on the one hand, and properties of the group situation on the other.

In this paper 2 different patterns in early group meetings, and the immediate problems they present in therapeutic management, are delineated. One, termed "the help-rejecting complainer," was shown by 2 women and a man; the other, termed "the doctor's assistant," by 4 men.

## II. Method.<sup>3</sup>

Our research population consisted of about 70 patients in 6 therapeutic groups. All were adult outpatients with psychoneuroses. Some groups contained only women, some only men, and some members of both sexes. The average attendance at the groups was 4 to 7, and they met weekly for an hour and a half with a psychiatrist. The groups were run very informally and the main emphasis was on creating an atmosphere in which patients would feel free to display their feelings and attitudes and study them. When possible, emphasis was placed on understanding the feelings and behavior aroused by the other group members as a way of gaining insight into their pervasive difficulties with people. Group meetings were recorded by experienced observers.

The first step in identifying these patterns was to look for consistent behaviors in the early group meetings that were readily identifiable by both therapist and observer. We looked especially for patterns shown by several patients, and that seemed to be related to data about these patients obtained from interviews and tests. These patterns were described in a preliminary fashion.

We then studied the narrative accounts of group meetings for every instance in their first 10 group meetings (or less if the patient did not attend 10) in which they did or said something. Those acts that seemed to bear a positive or negative relationship to the pattern were subjected to a situation analysis (4).

For each patient we summarized these situation analyses in terms of similar situational stimuli, behavior, and effects. Sum-

maries for all patients thought to have the same pattern were then compared. When differences were found, we re-evaluated our original observations, or searched for points we had overlooked. Patients showing variations not compatible with the pattern were dropped. For the patients who did appear to have the same pattern, we summarized in a single chart the common features of stimulus, behavior, and effects, taking care to note any apparent contradictions or inconsistencies.

Consideration of the pattern of behavior in its group setting yielded clues as to the attitudes underlying it or the issues that the patient appeared to be trying to resolve through it. We scrutinized all other data on these patients from interviews by psychiatrist, psychologist, and social worker for further evidence as to the nature of these issues, and for indications of similar behavior in the patient's daily life. We did not necessarily expect to find the same behavior in other situations, but rather attempts to deal in the same general way with the same issues, using behavior appropriate to the particular situation.

## III. Description of Patterns and Dynamics.

The pattern of the help-rejecting complainer is characterized by behavior suggesting that the patients fear they will be ignored by others unless they maintain a continuing claim of their attention. They do this by repeatedly presenting a complaint or problem, while at the same time implicitly or explicitly rejecting any advice or help offered. This pattern occurs with very little specific stimulation, other than what is implied in the therapeutic situation itself. Its effects are to cause other patients or the doctor to offer advice, and to impede or break the continuity of the group. The would-be help-givers soon become frustrated and annoyed.

A very different pattern, the doctor's assistant, is characterized by behavior suggesting that the patient is acting in accordance with what he conceives to be the role of the doctor in order to win the approval and respect of the doctor and other patients. It consists of offering advice to others, emphasizing one's own superiority and com-

<sup>3</sup> A full description of the method will appear elsewhere (2, 3).

petence, never asking for help, and resisting any admission of weakness. It tends to be stimulated by situations that appear to the

these 2 behavior patterns in comparative form. All the generalizations in this table were derived from actual data as described

TABLE 1

## COMPARISON OF PATTERNS OF HELP-REJECTING COMPLAINER AND DOCTOR'S ASSISTANT

|                        | Help-rejecting complainer  | Doctor's assistant  |
|------------------------|--|---|
| A. Stimuli             |  |   |
|                        | Patient exhibits pattern without apparent external stimulation. Appears oblivious of the immediate group situation in that this does not modify his behavior.  | Patient tends to exhibit pattern in response to an appropriate occasion, such as tension in the group, others seeking advice or help, or others presenting a problem. Appears constantly conscious of immediate group situation and tries to modify behavior to meet it.  |
| B. Behavior            |  |   |
| Toward doctor          | Addresses the doctor in an aggrieved, complaining tone. Acts as if seeking his help rather than his approval or respect. Usually rejects advice directly or indirectly. May verbally concur, without acting on it.   | Rarely addresses doctor, and then in a respectful way. Acts as if striving for his approval or respect rather than his help. Discourages others from giving him advice, by acting as if he doesn't need any.  |
| Toward other patients  | When not talking to doctor, addresses in a complaining tone chiefly those other patients who appear willing or able to offer advice. Stresses greater need for help than the others. Belittles others' complaints in the service of this. Gives advice only rarely, and then to dismiss others' problems. Becomes easily involved in contention. | Addresses chiefly other patients, in a patronizing or help-offering tone. Stresses superior competence or worth to others. Belittles others' complaints in the service of this. Gives repressive, platitudinous advice, in a help-offering way. Tries to avoid contention. Tries to terminate attacks by becoming either dogmatic or placating by, <i>e.g.</i> , indicating he was misunderstood, stressing good intentions, etc. |
| Characteristic content | Appears completely self-centered. Talks only of own problems and difficulties, which he exaggerates (but actually obscures them). Blames those on whom he depends, or authority figures, for his problems.   | Appears to concentrate on problems of others. Resists or evades revealing problems of his own, except those he claims to have handled successfully. Defends authority, represents its viewpoint. (Since he admits no problems, he cannot blame others for them.)  |
| C. Effects             |  |   |
| On doctor              | Irritates him by oppositional attitude, and thwarting his efforts to help other patients as well as himself.   | Pleases him at first by cooperative attitude, stimulating group interaction.  |
| On other patients      | Weakens or breaks continuity of group. Irritates, bores others. Gains disapproval or contempt of others. Causes certain others to offer help, advice.  | Stimulates interactions, often determines course of meeting. Irritates, bores primarily members who are sensitive to being dominated or made to feel inferior. Gains initial approval of members sharing his attitudes. May cause certain patients to seek advice.  |

patient to require someone's active intervention, and at first tends to relieve tension, though eventually it too becomes annoying.

Table I presents the salient features of

above, and each item applies to all the patients showing the pattern.

These patterns seem to bear no relationship to the usual clinical diagnostic cate-

gories except in one respect. The doctor's assistants tended to complain of bodily rather than psychic symptoms, which is consistent with the fact that the former can be attributed to physical illness and hence do not force them to admit a weakness for which they are responsible. The help-rejecting complainers, having no such compunction, freely complained of psychic symptoms. Two of them complained of anxiety and one of obsessional thoughts. Of the 4 doctor's assistants, on the other hand, 3 had ostensibly bodily complaints: one impotence, one hypertension, and one a chronic stomach-ache. The fourth had an anxiety reaction with compulsive manifestations, but he came for treatment ostensibly only because his boss insisted that he do so. Of the 7 patients, 4 would be considered to be obsessional, 2 of the help-rejecting complainers and 2 of the doctor's assistants. This is consistent with the rigidity of their behavior but seems otherwise unrelated to the patterns.

#### IV. *Therapeutic Considerations.*

From the descriptions of these patterns it is apparent that some aspects of both may constitute a challenge to the doctor's therapeutic skill, although the nature of the challenge is quite different for each. The pattern of help-rejecting complainer tended to interfere with the formation of a cohesive group and to put a great strain on the doctor's patience. The pattern of doctor's assistant presented problems of a more subtle nature centering on these patients' inability to tolerate even implied criticism in public. The following examples illustrate the types of problems presented by these patterns and some ways of dealing with them. Examples 1 and 2 show different reactions of group and doctor to patients showing the first pattern and their effects on the pattern.

*Example 1:* Mrs. Livingston, a 38-year-old married woman, came to group therapy after 5 years of unsuccessful psychiatric treatment, including hospitalization. Her main complaints were indecisiveness and feelings of futility. She complained that she was unable to plan her daily activities and constantly asked other people for suggestions, but did not find them helpful. She had an intense, aggressive manner, and a strident voice. She was placed in a group of 6 women who were all chronic complainers, and soon outstripped them with her repeti-

tive complaints and requests for advice, which she never accepted. Any attempt by other patients to discuss a topic of their own was promptly interrupted by her, and the group became annoyed as well as bored. Various members looked at the doctor hoping that he would stop her and he was made increasingly uncomfortable by the mounting group tension. During the fifth meeting when he asked Mrs. Livingston why she found it so difficult to listen to others, she came forth with a barrage of "the trouble with me is that I don't know what to do," etc., and continued to hold the floor for some time. The therapist tried then to interrupt her by addressing another patient. As soon as a brief pause set in, she promptly resumed her complaining and advice-seeking. The doctor then asked her whether she found it hard to tolerate periods of silence because of mounting tension in herself. She replied by more complaining, thereby increasing her own tension as well as that of the group and therapist. At the end of this meeting, as well as the preceding ones, Mrs. Livingston waited to talk with the doctor alone and then bombarded him some more with her complaints. He responded by busy-ing himself with the recording machine and urging her to join the other members who were leaving the meeting room. This type of encounter continued for three more group sessions with ever-increasing discomfort for all concerned.

Mrs. Livingston's behavior and the doctor's attempts to change it by direct intervention resulted in his paying more attention to her than to any other group member. One patient complained to him about this. Many of his interventions indicated that he was annoyed at Mrs. Livingston's constant complaining and even though they were meant to help other patients to have a chance to talk they actually frightened them. As one of them remarked: "I would be scared to death to complain because it makes the doctor angry."

The patients had no greater success in stopping Mrs. Livingston, as was illustrated in the ninth session. Mrs. Livingston had soliloquized for more than 15 minutes, in the course of which she again complained that she did not know what to do with herself all day long and that she continually had to ask her mother what to do. Her mother, she said, was getting fed up with her constantly asking, "What shall I do today?" as was her husband and even her young daughter. She envied everyone else because they had plans and she had none. She said that nobody understood her and all the advice she received was useless because nothing meant anything to her. The doctor, who previously had occasionally made vain attempts to satisfy her demands for advice, remained silent because he felt it was futile to intervene. Another group member, becoming increasingly impatient, finally tried to follow the doctor's earlier technique. She mentioned that Mrs. Livingston had talked about having a maid to help her do the housework and somewhat apologetically suggested that if she would do the work herself she would have less trouble filling her day. Mrs. Livingston snapped back, "Oh, you don't understand. The maid only comes once a

week!" After a brief pause she continued: "And even if I did the work myself, so what? Will I be any happier?" The other patient smiled at the doctor and shrugged her shoulders as if to say that there was little use trying to talk to Mrs. Livingston, who in the meanwhile resumed her soliloquy at the point it had been interrupted, apparently unconcerned by the obvious boredom and annoyance of the others. This continued for another 10 minutes when Mrs. Livingston, seemingly exhausted, said: "I guess my situation is hopeless." The therapist resignedly replied: "I think so too." This response stunned the patient at first, and after a few seconds of pause she asked him what he meant. The therapist let her know that he meant what he said, but refused to get into a prolonged argument on the subject. This interchange proved to be the turning point in Mrs. Livingston's behavior. She no longer monopolized the conversation by her repetitive complaining. For the first time she talked about her feelings toward her husband and for the first time the group, as well as the doctor, expressed interest in what she was saying. Unfortunately, the patient could not attend any more group sessions because she moved to another city. She wrote a letter reporting marked improvement, but the real extent and permanence of this could not be ascertained.

*Example 2:* Mrs. Fielding came to group therapy with the complaint that for many years she had been suffering from severe headaches. She said they were caused by menopause, even though she was only 42 and a number of doctors had told her that "it was her nerves." When she was placed in an all-women's group that existed for several months, she immediately turned her chair so as to face the doctor directly and away from the other patients. The conversation was lively and characteristic of a group that had developed a good deal of cohesiveness. Mrs. Fielding seemed disinterested in what was going on and only waited for a lull in the conversation to present her complaint of headaches to the doctor. She asked him repeatedly if he thought they were due to menopause and what she could do about them. Without waiting for him to answer the first few questions, she presented a set of new ones and was beginning to annoy the group, which was obviously bored by the nature of her complaint and the fact that she was trying to disregard the topic that had been under discussion. The doctor's annoyance began to mount and he was tempted to interrupt the patient as he had tried to do with similar patients in previous groups. Being aware of the fact that it had not worked too well and convinced that the group was strong enough to take care of itself, he decided to change his tactics by remaining silent and waiting for the group to handle the problem. As she was a new member, the other patients showed her considerable politeness at first. Some of them tried to reassure her that they too thought in the beginning that they had a physical disease, but that they subsequently learned of their emotional problems. Mrs. Fielding ignored their statements and continued to present her complaints to the doctor. At the end of the

meeting, while the other patients were leaving, Mrs. Fielding waited for the therapist and told him once more that she had headaches, etc., as if unaware that she had repeated the same story at least a dozen times. The doctor politely pointed out that the other members were waiting for her and suggested that she join them.

The next group session started out similarly. However, the group seemed prepared to challenge the new patient's behavior by attempting to inquire about her personal relationships. Mrs. Fielding at first refused to comment but eventually admitted that she had a good deal of trouble with her son who was "unappreciative, sassy, and without feelings." She promptly added, however, that this had nothing to do with her case, which was caused by menopause. The group followed with a very tense discussion about parental attitudes toward children in which Mrs. Fielding, though obviously interested, did not participate. She showed this not only by turning her chair from the doctor toward other patients but also by much less interrupting, even though she continued to come back to her self-centered complaining from time to time.

The next 2 sessions showed a gradual change in her behavior. She began to get interested in others' problems and occasionally even gave advice instead of asking for it. When one member directly criticized her for being "cold" with her son, others came to her defense. It was apparent that she had now become more a part of the group. When at one point she drifted back into the old pattern, the therapist asked her why she felt that she had to repeat herself so many times. He said that he wondered why she seemingly had so little self-respect that she did not consider herself worthy of being listened to. Other patients assured her that they appreciated how much she suffered from her headaches and that they understood her misgivings about attributing them to emotional problems. From this time on Mrs. Fielding no longer glared at the doctor during group sessions and no longer waited to have him "alone" at the end of the meeting. She continued to talk more and more about her difficulties at home and began to accept the possibility that the headaches might be connected with them. She not only listened to advice offered by others, but actually attempted to carry some of it out and not without success.

Difficulties in treatment of a different kind may be illustrated by the following example of the pattern of doctor's assistant.

*Example 3:* Mr. Shofer, a 30-year-old accountant, came to group therapy at the suggestion of the doctor at his place of work. He was irritable with his fellow-workers and constantly complained of what he considered their lack of efficiency. When he arrived for the first meeting he was immaculate in his dress, erect in posture, and outwardly calm and poised. Only a trained observer could discover a moderate tremulousness of his lips and hands. The beginning moments of the newly formed group were tense with most members waiting for either the

doctor or another patient to make the first move. After a few attempts by several to state their reason for coming for treatment—which led nowhere as far as the development of a topic of conversation was concerned—Mr. Shofer briefly looked at the doctor, sat up in his chair, and then with apparent self-satisfaction said: "Well, I might as well get the ball rolling." He then proceeded to speak for several minutes on self-control and elicited a good deal of comment from other members as well as the doctor. Mr. Shofer, realizing that he had succeeded in reducing the tension in the group, again briefly looked at the doctor and was pleased to see that he too was more relaxed as the result of his efforts.

The fact that much of what he said was meant to point out his superior ability in achieving emotional control seemed to matter little at first, since everyone welcomed the relief from tension. As the patient continued to speak of his virtues, such as having overcome a nervous breakdown while studying for the ministry, other members began to challenge him about his ideas on self-control. He avoided an argument by concentrating on the problem of the others rather than revealing anything about his own. This happened in the second group meeting when the doctor attempted to draw in a silent member, Mr. Traub, by asking if he, like the other members, had a boss. Mr. Traub said his trouble was that working in a government agency he didn't have a real boss and so didn't know whether he was doing too much or too little at work. Mr. Shofer then entered the conversation by asking: "You feel your supervisor is trying to undermine you? Does he keep all the work on his desk as a sign that he is a supervisor to you?" Mr. Traub was evasive under Mr. Shofer's continued questioning but did tell how he had recorded that a woman had paid her debts although he had no proof of this and his supervisor caught the devil for it. Mr. Shofer said pontifically: "In my estimation, you have a good boss."

A little later Mr. Shofer seeming very puzzled said to Mr. Traub: "In other words, your problem is, are you doing good or bad work?" Mr. Traub replied: "No, but whether too much or too little." Mr. Shofer repeated this: "Worried about doing too little." Mr. Traub shifted again: "No—but it's the kind of work—I'm interested in quality."

Mr. Shofer went on for several minutes in this way, continuing to get evasive answers from Mr. Traub. Finally he stated rather pompously: "Your problem is not understood by me. You have your heart in your work. I don't know what could be worrying you about your job." Mr. Traub caused general laughter by saying, "Who said I was worried about the job?" Mr. Shofer reiterated: "I can't understand what your trouble seems to be." Mr. Traub concluded this interchange by saying: "I can't either."

As the group progressed Mr. Shofer continued in the same role, i.e., the one who keeps the ball rolling and gives the advice because of his greater experience and knowledge. Other patients began to wonder why he came for treatment since he seemingly had no problems now and told only how he had successfully handled them in the past. Because of

this, as well as his tendency to belittle their concerns, they grew increasingly annoyed with him and also questioned him more about his personal affairs. The doctor, who was aware of his great vulnerability, felt alarmed by this development because he feared that too much pressure would drive him out of the group. This did, in fact, occur after he had difficulty resisting a direct request by another patient to talk about his marriage and divorce after the latter had done so himself. Although he tried to emphasize the virtue in having been able to tolerate suffering (he stayed married to his wife for many years even though he knew of her promiscuity and was beaten up by her on many occasions), the group mockingly called him a "glutton for punishment."

Mr. Shofer did not spontaneously return for any more group meetings. The doctor made several attempts to get him to come back, but he dropped out of the group for good after one more appearance during which he was silent and more aloof than ever.

#### DISCUSSION

The patterns here described presented important therapeutic problems from the standpoints of the patients showing them and the group as a whole. They had marked effects on the growth and functioning of the group that the therapist could not ignore. Each pattern also seemed to represent a way of dealing with an important personal issue or a group of issues that were closely related to the patients' neurotic difficulties, and therefore were of therapeutic concern.

*The help-rejecting complainers* seemed to have an indiscriminate need for help and attention, and to see themselves as completely dependent on other people. At the same time they seemed to perceive the potential help-giver as indifferent to their plight or unable to meet their needs, or both. This made them angry at him, leading them to anticipate his anger in return and strengthening their belief in his ill will. The pattern seems to represent an attempt to resolve the problem of feeling dependent on someone whose good will and competence one distrusts and at whom one is angry. By continually complaining while directly or indirectly rejecting all offered help, these patients succeed in maintaining their claim for help, justifying their anger at the potential help-giver, and avoiding the danger of slipping into his power by becoming really dependent on him.

This pattern was constantly stimulated by the help-giving character of the psychotherapeutic relationship. The initial group situ-



ation in which other patients were regularly perceived as rivals for the doctor's help might further intensify it. The irritating influence on the group and the doctor, as well as the tendency to speak chiefly to the doctor, usually interfered with the development of group cohesiveness; other patients began to look upon the group as an arena in which one's individual concerns were presented to the doctor before an audience. In addition, they began to lose interest when they found that there was little opportunity even for that when the complainer monopolised the conversation, as he often did. His demands for advice tended to force the therapist into the position where he had either to give premature and ineffective advice, or to spend most of the time avoiding doing so. Since the complainer was persistent, this often resulted in an unfruitful struggle that added to the disruptive influence on the group.

The therapist might find himself in the position where he would seriously consider "sacrificing" the one patient by direct interruption or rebuff in order to preserve the group. But this was not easily achieved because the complainer was relatively insensitive to bluntness and correction. Furthermore, to tell one patient, for example, to keep quiet or to leave the group might make other members fearful that they would be treated in a similar manner if they complained about their own troubles, as in Example 1. Yet the group expected the doctor to do something, particularly if it had not yet developed enough strength of its own to cope with such a difficult member.

The complainer's need to point up the futility of the advice given is indicative of a feeling of hopelessness that pervades most of his actions. Since he regards the helper as incompetent and ill-disposed, the therapist will gain little by offering help. The patient is fully aware that he irritates the doctor as well as other group members by his hostile behavior, but finds justification for it when they (doctor and patients) counter with hostility of their own, which in turn perpetuates the pattern. A possible way out of this vicious circle may be for the therapist to indicate that he not only understands but shares the patient's feelings of hopelessness, thus refusing to perpetuate his part in

a futile relationship. Two patients, who had had lengthy individual treatment without much benefit (one in addition to Mrs. Livingston described above), responded to this by breaking off treatment and reporting marked improvement, as if to prove to the doctor that he was wrong. Whether this apparent improvement represented anything more than this could not be determined.

Our second example suggests that patients showing this pattern may do better in a well-established group than in a newly formed one. An older group has developed a sense of responsibility for its own successful functioning, and therefore is prepared to tackle patients showing this pattern rather than expecting the therapist to do so. The patient may be more accessible to certain group members who, not being authority figures or help givers, may not elicit the pattern to the same extent as the doctor and can be both challenging and supportive in ways not open to him. The doctor, not feeling pressed to do something about the situation, can be supportive without being either help-giving or rejecting. In our example the result was that the behavior pattern changed after but a few group meetings and the patient became well integrated in the group.

*The doctor's assistant* presented a therapeutic problem of a different sort. Patients showing this pattern appeared to have a strong need to win the approval and respect of an idealized authority. They believed this respect was to be won by patterning themselves on such authority, that is, by being manly, self-controlled, self-sufficient, and competent in carrying out orders. While admiring authority in the abstract, they tended to be critical of any particular authority for falling short of this ideal. These feelings, as well as their awareness of flaws in themselves and of strong emotions that they feared would get out of hand, prevented or threatened to prevent their winning the respect they craved. The pattern seems to be an attempt to win this respect by acting in the approved way, by trying to conceal their weaknesses, and by trying to avoid emotional stimulation.

The psychotherapeutic relationship was especially difficult initially for these patients because of its implication that they were in need of someone else's help, in itself a severe

admission of weakness. The group situation, with its pressure to discuss personal problems and reveal feelings, was especially threatening. In early meetings especially, they found themselves in acute conflict because to gain the doctor's approval seemed to involve revealing personal flaws that weakened their claim to respect.

In contrast to the help-rejecting complainers, who were annoying and disruptive, these patients stimulated group interaction directly or by arousing antagonism through their attitude of superiority, which the other group members found easy to attack. In addition their tendency to give advice and to answer questions directed at the doctor relieved the therapist of the burden of doing this himself at a time when he considered it ill-advised or premature. Because the therapist was pleased by this type of assistance, there was an inclination to overprotect this type of patient. This might be quite useful since the doctor's assistant could not take much criticism from the other members and he was so readily attacked by them. There was, however, some danger in showing too much consideration. The group members often were suspicious that these patients were planted informers, and they might become strengthened in this belief by the doctor's protective attitude.

This behavior pattern might invite a totally different reaction on the part of the therapist. Since the doctor's assistant tried to display complete competence, the doctor sometimes considered him less vulnerable than he actually was and might fail to protect him or even join the group members in undermining his "superior" position. With or without the doctor's support, these patients did not seem to survive many group meetings. With increasing pressure by the other patients for self-revelation, they felt that they had made or would make fools of themselves by remaining in the group and abandoned it for good at a point when their shaky position of superiority became untenable, as in Example 3. There seems to be no effective way for the doctor to counteract threats to these patients' self-esteem, which are certain to arise in early group meetings, since support in public is felt as derogating. Perhaps such patients should be treated in individual interviews as well, through which

they may gain security and also learn to modify their approach to the group sufficiently so as not to invite its censure and criticism to the same degree.<sup>4</sup>

#### SUMMARY

Successful treatment of patients in groups requires consideration of the needs of the individual patients as well as the group as a whole. Understanding of these needs may be aided by the identification and study of behavior patterns shown by patients in early group meetings. These patterns often reflect the patients' habitual ways of dealing with important personal issues, and may strongly influence the group's functioning. As such, they seem to be more closely related to the therapeutic process than are clinical diagnoses in terms of symptoms. This paper outlines a method for identifying such patterns and describes two of them. That of the "help-rejecting complainer" consists essentially of constantly demanding help while denying its usefulness, and seems to express both the patient's feeling that he needs help, and his distrust of all potential help-givers. The "doctor's assistant" stresses his own competence, gives advice, and refuses to admit weakness as ways of claiming superiority. This pattern seems to represent these patients' way of dealing with their conflicting attitudes toward authority. The therapeutic problems posed by these patterns for both the patients and the group in early meetings are discussed.

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<sup>4</sup> As a rule, patients showing this pattern were considerably more comfortable in individual sessions. More recent experiences indicate that regular supplementary individual interviews may enable these patients to gain therapeutic benefit from the group.

## A SPECIFIC TREATMENT FOR NEUROVEGETATIVE DYSTONIA

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With the increase in our military strength, military medicine assumes greater importance. Such an increase in military activity can lead to extensive medical complications during the quiescent period following the demilitarization. Today, in the psychiatric clinic of the Veteran's Administration, one may see many cases that are possibly a result of previous military duty.

The need of long medical treatment in many neuroses is expensive and is a severe strain on the national budget. It is important to re-evaluate and analyze the emotional conflicts or neuroses that followed war experiences in the second world war, in an effort to determine finer screening methods that might avoid future increase in psychiatric cases.

The following report is an evaluation of 32 veterans, studied and treated between January 1947 and January 1948, all of whom came to the private office of a qualified psychiatrist on the O. P. P. panel system of the V. A. office. The physician was chosen by the veteran himself from an approved list. Each patient presented a variety of functional symptoms related to various organic systems. Treatment consisted of 2 concomitant methods: (a) psychotherapy and (b) combined drug therapy—a combination of ergotamine tartrate, Bellafoline, and phenobarbital (Bellergal) to alleviate some of their associated somatic complaints (1). The investigation of these cases can be divided into 4 phases:

1. Premilitary—environment, parental surrogates, and other influencing factors are analyzed.
2. Military phase—the ease of adaptability to new surroundings and the incidence of traumatic neuroses are studied.
3. Post army civilian phase—the adjustment of these patients to civilian life and the causes for their neuroses are brought out.
4. Treatment phase and results.

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*Premilitary Phase.*—It is not an easy matter to predict which individuals may eventually develop a neurosis following stress situations. Karnosh and Zucker (1) point out, "In general, a psychoneurotic person is excessively aware of himself and any sensory experiences which may arise from his bodily functions." These individuals have a strong tendency and desire to discuss their various tensions and to obtain assurance as well as drugs. It is important, as physicians, to remember that these disturbances are real, not imaginary, and must be treated with as much thought and care as actual organic lesions.

We were able to discern factors of instability and poor adjustment in a review of the premilitary life in our cases. It is impossible to state whether one could, at that time, predict the future neuroses and emotional breakdown, had the patient been given a psychiatric interview. As Fenichel (2) points out "... in the same way that the cortex organizes, leads, and inhibits impulses of the deeper and more archaic levels of the brain—it can be stated that the common denominator of all neurotic phenomena is an insufficiency of the normal control apparatus."

*Military Phase.*—This phase of the patients' life may very well be the focal point of their difficulties. However, it is our belief that their illnesses were not necessarily precipitated by their army career. The army experience only aided in speeding up or exaggerating the emotional weaknesses inherent in these patients. Table 1 lists the number of our patients with the length of their military service, the type of duty, and the diagnosis of discharge. This table shows no relationship between any of these factors and future difficulties. Trauma may result in mental or emotional conflicts in either of 2 ways: (3)

1. Direct structural injury to the brain giving rise to organic reactions with subtle changes occurring in personality.

2. Emotional disturbances that in one form or another are continued over varied

lengths of time. These reactions are usually manifested as psychoneurosis.

Combat fatigue or neuroses are usually classified in this second group. According to Karnosh and Zucker(1) the most common of all neuroses in World War II was the anxiety syndrome representing a carry-over of civilian neurosis into the war situation. Naturally, many of these cases could be avoided with adequate selective methods. Anxiety subjects are usually conscientious, worryful men who are confronted by con-

ditions(4). Two important points can be obtained from this report:

1. The American soldier obtains great moral strength from his membership in a team and from loyalty to his leader. This group life is his inner life. When an individual member of a combat group has his emotional bonds to this group seriously disrupted, then he, as a person, is thereby disorganized. This disruption of group unity is, in the main, a causative factor, not a secondary effect of personality disorganization.

2. The picture of psychological disorganization in combat neuroses does not correspond to any recognized established psychiatric syndrome.

*Postmilitary and Civilian Phase.*—Releasing an individual from strict supervision may result in a period of indiscreet and uncontrolled behavior. An emotionally balanced person will soon adjust himself and will resume his responsibilities. In any post-war period there will be some individuals who will find it more difficult to become readjusted to civilian life. It will take these persons a long period to get good jobs, to become good family men, or to take their accustomed place in society. Our patients were among this group that were unable to cope with the transition from army to civilian life.

Recent medical studies have led to a better understanding of the role that emotion plays in disease. Selye(5) in his general adaptation syndrome shows the relationship of stress situations to systemic or general non-specific changes. "The diseases of adaptation are defined as maladies referable to an abnormality of the adaptation-process itself, to maladaptation." Both Cannon(6) and Ivy(7) have shown that bodily reactions take place following emotion-producing situations. The emotions then can be regarded as the intermediary pathway between the conscious mental reaction and the bodily organs through which one affects the other.

Psychosomatic approach to disease calls to attention the interplay of mind and body. Burlingame(8) pointed out that it was now no longer possible to distinguish "mental" from "physical" ills—"there is only disease." He pointed out that every disease presented both somatic and psychic aspects. Burlingame felt that general paresis was

TABLE 1

| A. Length of duty (months)                      | No. of patients |
|---|-----------------|
| 12-18 .....                                     | 1               |
| 18-24 .....                                     | 6               |
| 24-30 .....                                     | 4               |
| 30-36 .....                                     | 5               |
| 36-48 .....                                     | 9               |
| 48-54 .....                                     | 1               |
| 54-60 .....                                     | 1               |
| No data .....                                   | 5               |
| B. Type of duty                                 |                 |
| Combat .....                                    | 21              |
| Overseas-no duty.....                           | 3               |
| Continental .....                               | 4               |
| No data .....                                   | 4               |
| C. Types of military discharge and % disability |                 |
| C.D.D.* .....                                   | 7               |
| C.D.D. 10% .....                                | 1               |
| C.D.D. 50% .....                                | 3               |
| C.D.D. 100% .....                               | 1               |
| Service .....                                   | 9               |
| No data .....                                   | 7               |
| Medical .....                                   | 1               |
| Medical 10% .....                               | 2               |
| Medical 80% .....                               | 1               |

\* Certified Disability Discharge

flicts of fear and other emotions. Naturally, every soldier is expected to submerge all of his ego demands into a common cause. Individual desires and drives must be repressed willfully by self-discipline or by strict discipline inflicted by others. Many tensions are relieved by the busy activity of well-regulated army life. However, the individual balance can be easily upset by added stress or strains. Bad weather, loss of sleep, lack of food or water, bad news from home—all can aid in hastening the onset of combat fatigue.

A report on combat fatigue carefully analyzed the precipitating factors in these con-

50% psychic and 50% somatic. Ebaugh(9) pointed out in the light of these newer concepts that treatment must be aimed at the patient and not the disease.

*Treatment.*—In view of the above discussion it is clearly seen that it is essential to embody in the treatment of functional disorders (psychosomatic problems) measures

TABLE 2

| Types of complaints   | No. of patients |
|---|-----------------|
| Nervous .....   | 27              |
| Anxious .....   | 24              |
| Tense .....   | 15              |
| Insomnia .....  | 15              |
| Restlessness .....  | 13              |
| Moody and irritable.....  | 14              |
| Gastrointestinal complaints (belching, nausea, diarrhea, indigestion, etc.).. | 14              |
| Headaches .....   | 18              |
| Tremulousness .....   | 17              |
| Emotionally unstable.....   | 15              |
| Palpitating heart.....  | 25              |
| Poor appetite.....  | 14              |
| Intense fear.....   | 14              |
| Fatigue .....   | 25              |
| Clearing of throat.....   | 1               |
| Psychosomatic (bodily aches and pains) .....                                  | 7               |
| Inability to work.....  | 25              |
| Jumpy .....   | 15              |
| Worried .....   | 14              |
| Depressed .....   | 13              |
| Dizziness .....   | 15              |
| Pyrosis .....   | 21              |
| Dreams .....  | 21              |
| Sweating .....  | 14              |
| Loss of weight.....   | 2               |
| Weakness .....  | 25              |
| Colds .....   | 1               |
| Chronic cough.....  | 1               |
| Ringing in both ears.....   | 21              |
| Lachrymose .....  | 1               |
| Stammering speech.....  | 2               |
| Blackout spells.....  | 21              |
| Nail-biting .....   | 21              |
| Lack of ambition.....   | 1               |
| Heavy drinking.....   | 21              |

that will adequately control the psychic and somatic components of these conditions.

Our patients presented a wide variety of symptoms, all of which fall into the category of psychosomatic complaints (see Table 2). Physical examination showed no organic lesions that could be the etiologic factors causing the organ symptomatology (Table 3 lists the results of physical examination). Enough time had elapsed between discharge and the first visit that environmental factors

of army life could not be blamed for the manifestations of emotional instability (see Table 4).

In order to best treat these patients, the therapeutic program was divided into 2 parts: (1) psychotherapy—reeducation—adaptation and (2) drug therapy.

1. Psychotherapeutic sessions of 45 minutes or more were employed since it was felt that these psychosomatic disturbances were the result of deep-rooted traits. It was important to get a better understanding of the patients' past in order to learn the basic causes for the present conditions. Private

TABLE 3

| Results of physical examination | No. of patients |
|---------------------------------|-----------------|
| Negative for any pathology..... | 17              |
| Dermatitis .....                | 1               |
| High blood pressure.....        | 15              |
| Heart rate rapid.....           | 14              |
| Body moist.....                 | 12              |
| Dripping sweat.....             | 12              |
| Hyperactive reflexes.....       | 21              |
| Asthenia .....                  | 2               |
| Impaired breathing.....         | 1               |
| Tachycardia .....               | 21              |
| Underweight .....               | 12              |
| No data.....                    | 11              |

TABLE 4

| Length of time from discharge to first visit (months) | No. of patients |
|---|-----------------|
| Under 12.....   | 4               |
| 12-17 .....   | 9               |
| 18-23 .....   | 4               |
| 24-29 .....   | 6               |
| 30-35 .....   | 3               |
| 36 plus.....  | 1               |
| No data.....  | 5               |

office interviews were held. An effort was made to put the patient completely at ease, and in a mood to ventilate all his problems and conflicts.

2. Drug therapy—vitamins were prescribed to those individuals presenting any nutritional deficiencies, and any minor organic ailments were treated as indicated.

It was our feeling that the patients would respond more rapidly to psychotherapy if adequate relief of the organ symptomatology could be obtained. Several reports on the use of a neurovegetative sedative have appeared in the literature indicating that relief of functional ills could be obtained with such a preparation(10-14).



Heath and Powdermaker (15) pointed out that "in the war cases there is purely an exaggeration of the normal reaction of the sympathetic nervous system to fear." In a true neurosis there is apt to be a complicated and unpredictable pattern of autonomic imbalance. In traumatic reactions the symptoms are clear cut and obviously due to sympathetic dysfunction. Several workers therefore (15-18) used ergotamine tartrate singly or with central sedatives for the treatment of the acute attack. Although the results are varied, ergotamine is indicated in that it is a sympathetic inhibitor and does reduce the severity of tremor and restlessness, the 2 most common symptoms of this condition.

In anxiety neuroses and functional disturbances the entire neurovegetative system is affected. For this reason, it is theoretically sound to aim drug therapy at all three of the nervous systems and we believed that the drug of choice would be one that could sedate all 3 systems at once: (a) vagal sedative—bellafoline, (b) sympathetic sedative—ergotamine tartrate, and (c) cerebral sedative—phenobarbital.<sup>2</sup> Although this combination contains single components affecting different divisions, the preparation, as a whole, produces a unified action. Rothlin (11) showed in pharmacologic studies that by joint administration vagal and sympathetic depressors were not antagonistic to one another. Instead of a neutralizing effect each drug affects its respective reactive system.

The patients in our group sought medical aid primarily for relief of their symptoms; they did not realize the psychological involvement but thought that they were suffering from organic lesions. With the relief obtained with the drug, Bellergal, it was easier for them to grasp the relation of their personal problems to their complaints. They were then in a more cooperative frame of mind for psychotherapy and there was a closer patient-physician relationship.

It is difficult to study each case and carefully delineate each of the periods in a patient's life. Careful analysis, however, leads to some segregation. In this way, the pa-

tients could get a proper understanding of the strands that continue from one period to another. The following case histories typify our experience in this series.

*Case 9:* Premilitary. Patient was next to youngest in his family of 10. He denied any nervous disease in the family. Father was domineering, with the family environment "full of tension." In retrospect one can see how his early life influenced and predisposed him to anxiety neurosis for he was considered weak and enuretic up to the age of 10. He left high school after 3 years but was told during this period that he had infantile TBC and an enlarged heart. He was, therefore, placed in special classes with other crippled children. This caused him to develop a bad inferiority complex. In order to prove to himself and to his family that he was in no way physically handicapped, he joined and was accepted by the army.

Military experience—his basic training was normal; had a fear of flying and resigned overseas air corps duty. He spent 2 years in the South Pacific, where he began to develop nervousness, loss of appetite, and insomnia. He was transferred and was then hospitalized in the United States for 7 months. He was discharged with a 50% disability. One and one half years after discharge he consulted the writer.

Postmilitary life—patient became fairly well adjusted to surroundings but any stress or strain tended to cause gastric complaints and nervousness. He was given psychotherapy plus Bellergal and showed little improvement at first. His symptoms were relieved and then he began to understand all the mechanisms of anxiety and why he reacted with so much hostility to his environment. He began to feel less tense, less nauseated, with a gradual disappearance of his gastric complaints. An occasional period of stress or strain caused a return of his complaints. Physically, he was practically well.

This patient showed much repressed material plus emotional charges attached to certain infantile and childhood developmental experiences such as being declared physically unfit to continue school with normal individuals. The same reaction was observed when the external stress and strain of army life became unbearable. A gradual maladjustment to his surroundings and situations caused him to express himself with acute attacks of anxiety. Resentment and hostility to his environment aggravated the situation so that when his particular buddy reprimanded him, telling him to snap out of it, the patient became most resentful toward him.

This patient, diagnosed as psycho-neurosis and anxiety state, showed good improvement with our particular method of therapy after 24 sessions. Prognosis was good and general management rather successful.

*Case 19:* Premilitary history—this patient fell on a cement floor at the age of 10, striking his head, and was unconscious for a short time. X-rays were negative. While in high school he had frequent headaches, lost interest in studies, and quit in his sophomore year. He was very religious (Catholic)

<sup>2</sup> Trade name for this combination—Bellergal.

and desired to become a priest. Although his ambition was great he did not follow this career.

Military history—marked difficulties in the navy and went AWOL for 30 days. He was in the South Pacific for 1½ years and was given a medical discharge in 1944. He was hospitalized in the navy for his headaches. He noticed that he became tense, nervous, irritable, and nauseated at the period when his headaches were worse.

Postmilitary—patient had a difficult time adjusting himself and took part-time jobs in the post office but did not keep these positions long. He frequented high school with the aim of becoming a social worker. He continued to complain of headaches but complete physical examination was negative. The patient was very religious. He had no sexual intercourse with his wife, since he claimed that he was not economically situated to raise a family. For this reason he practiced masturbation, which caused an increase in his guilt feelings, with severer headaches. (His wife was interviewed and appeared immature and indifferent to her husband's action. She was religious and had, at one time, desired to become a nun.)

The diagnosis was hypochondriasis. Owing to an unhappy home and few recreational outlets, the patient had led a solitary life marked with an intense feeling of insecurity that caused him to magnify the normal sensations of fatigue. He became overconcerned about his health with a compulsive expiation of a feeling of guilt. He showed exaggerated personality inadequacies and overconscientiousness.

Case 5: Premilitary—family history shows strong traces of epilepsy. Mother died at the age of 42 of epilepsy, and an older sister died as an epileptic. The third child is a younger brother who had no signs of epilepsy. Patient's early life shows good adjustment and normal development; he had no difficulty getting along with other people.

Military history—he went into the navy and served in the South Pacific on board a destroyer. His ship was hit by a suicide plane, killing a number of men. The patient claimed that this ordeal did not upset him, but instead of being returned to the United States he was transferred to another destroyer ready to take off for action. At this point, "something snapped in me." He had a period of amnesia for all events until he awakened in a hospital in Fort Worth, Texas. The length of this period of amnesia is undetermined. The patient woke up in a disturbed ward and received 10 electroshock treatments. He was hospitalized 5 months and then was discharged after having served 2 years.

Postmilitary—the patient found it difficult to adjust himself following discharge and it is apparent from his history that, anticipating a return to combat, all the instincts of self-preservation were brought out. This led to a period of amnesia and confusion that included anxiety and agitated reactions. This "complete fatigue" type of reaction gradually changed into one of neurosis with manifestations of anxiety, restlessness, nervousness, and worry about the future. This patient was encour-

aged to avoid repressing his desires; to become less tense in the face of environmental stress and strain. With psychotherapy and mild sedation, he gained some degree of self-understanding. Such traits as nail-biting have gradually disappeared, showing better emotional adjustment.

These cases are interesting in that they show abnormal reactions to stress situations that occur in everyone's daily life. These individuals present patterns of emotional instability dating from their early life. When stress situations occur, they are less and less able to cope with them and finally a functional breakdown is manifested by various symptoms and complaints. It would not always be easy to see which of these individuals or similar individuals would develop such functional ills from a "premilitary" history. Certainly, the histories of these men at the time of induction would be indicative of weak, insecure backgrounds and foundations. One might suspect that functional ills might be imminent.

The use of a neurovegetative inhibitory drug such as Bellergal in the treatment of these cases, once they have reached the psychosomatic stage, gradually enhances the effectiveness of psychotherapy. By relaxing the organs, by compensating for sympathetic and parasympathetic overactivity, and by decreasing the intensity of the central reactions, which are primarily conscious, much benefit can be obtained by the patient.

## CONCLUSIONS

1. One can conclude from such a study that great care in interviewing individuals should be taken. Individuals from unstable backgrounds, *i.e.*, alcoholic families, split families, religious conflicts, or orphans, should be interviewed with care. There is a tendency for these individuals to overcompensate for their poor start in life. By careful screening acute military reactions can be avoided.

2. Combined reactions are mainly a manifestation of the instinct of self-preservation. Individuals who have to struggle from the beginning have a greater drive for self-preservation as an overcompensating mechanism.

3. Functional or psychosomatic ills probably occur as an accumulation of all the stresses and strains in the patient's past his-

tory. In the treatment of our patients, Bellergal has proved to be an excellent adjunct in psychotherapy. The symptoms referable to all the organs of the body can be greatly alleviated by the judicious use of this therapeutic agent. By reducing the acute symptoms, the patient is not as aware of his bodily functions and is in a better frame of mind to respond to psychotherapy.

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## THE PSYCHIATRIC RESOURCES OF NEW JERSEY

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"My first-born child" is the way Dorothea Dix used to describe the New Jersey State Hospital at Trenton. This was the first state hospital built through her efforts—the enabling act was passed in 1845. It was to Trenton State Hospital that she returned in 1881, where she remained until her death in 1887, an honored and beloved guest. The room in which she lived is still preserved as a vivid memorial to one of the most valuable citizens of the 19th century and as a memento of one of the most effective crusades in psychiatric history.

New Jersey's state psychiatric institutions include 3 state hospitals for the long-term care of the mentally ill; 4 schools or colonies for mental defectives; a village for epileptics; a residential diagnostic center; a state child treatment center; and a residence center for the intensive treatment of youthful offenders.

These institutions are under the supervision of the State Department of Institutions and Agencies, which controls as well the state sanatorium, board of child welfare, penal and correctional institutions, and several special agencies for assistance to various categories of welfare clients. The Commissioner is Mr. Sanford Bates. The Deputy Commissioner, responsible for hospital and mental hygiene activities, is Dr. Edward J. Humphreys, a Fellow of The American Psychiatric Association.

A new state hospital is now in the process of construction near Atlantic City. The three existing state hospitals are at Greystone Park (average census: 6,200), Trenton (4,000), and Marlboro (3,200). Greystone Park (which is near Morristown) is the institution referred to in the second half of the phrase "Columbia-Greystone" Associates, by which the pioneer topectomy project is identified. Marlboro is near Asbury Park.

Six counties also operate hospitals for the long-term care of the mentally ill. These

are at Cedar Grove<sup>1</sup> (Essex County), Se-caucus (Hudson County), Northfield (Atlantic County), New Lisbon (Burlington County), Bridgeton (Cumberland County), and Grenloch (Camden County).

For the care of mental defectives, there are 2 state institutions for males (Woodbine and New Lisbon) and 2 for females (Totowa and Vineland). The Vineland State School is across the street from the famous Training School, the private institution where H. H. Goddard did much of his pioneer work in psychometrics. It was at Vineland that the Binet-Simon tests had their first large-scale usage in America.

The State Village for Epileptics is at Skillman, near Trenton.

Unique among correctional institutions—if it can be called an institution at all—is "Highfields," an experimental project for youthful offenders, housed in the former Lindbergh estate at Hopewell. Colonel and Mrs. Lindbergh donated this property to the state so that it could be used to advance the cause of welfare of youth and children. With the aid of grants from the Vincent Astor Foundation and from the New York Foundation, Highfields is being operated as a small home for youthful offenders who are, to all intents and purposes, as free as if they were on probation. It represents an extraordinary experiment in day-by-day group therapy, and is being watched with considerable interest as one of the few practical mergers of psychiatry and penology ever to be placed in operation. Less than 2 years old, the project has not reached the state where long-range evaluation can be made, but preliminary results have been encouraging. The evaluation study began in March 1951 under direction of the Department of Sociology at New York University.

<sup>1</sup> The late Dr. Samuel Hamilton, after his presidency of The American Psychiatric Association, was superintendent of this hospital.

The Diagnostic Center at Menlo Park (near New Brunswick) is another unique institution. It provides both inpatient and outpatient diagnostic services in all facets of psychiatry, psychology, neurology, and social studies, and is used principally, but not exclusively, for the evaluation of young violators of the law or persistent antisocial behavior.

Possibly the only separate state-operated treatment center for emotionally disturbed children in the country is the Arthur Brisbane Center at Allaire, near Freehold. Housed on an estate donated by the family of the late journalist, Arthur Brisbane, this Center provides diagnostic and therapeutic facilities for psychotic or prepsychotic children or for those suffering from "primary" behavior disorders of all sorts.

The Veterans Administration Hospital at Lyons (near Plainfield), is a 2,000-bed, predominantly psychiatric institution that has pioneered in special forms of electric shock therapy and in advanced professional education in psychiatry. Together with the state hospital at Greystone Park, these 2 New Jersey institutions furnished most of the source material and facilities for the now famous topectomy study<sup>2</sup> generally called the "Columbia-Greystone Associates Project." (This entire project, incidentally, grew out of a course given under the auspices of the New Jersey Neuro-Psychiatric Association in which Dr. Mettler was one of the lecturers.)

New Jersey has 81 general hospitals. In a recent survey by English,<sup>3</sup> it appeared that 53 of these had psychiatric facilities; 32 had clinic services but no inpatient facilities; 15 had psychiatric sections or departments in the hospitals but no outpatient services; and 6 had complete departments, both inpatient and outpatient. The new 950-bed Veterans Administration Hospital at East Orange will have a 250-bed psychiatric section when it opens this summer. This will be the largest psychiatric section in any general hospital

in New Jersey. The other general hospitals having psychiatric wards have sections averaging 15 to 30 male and as many female beds, each.

In the field of outpatient services, New Jersey was one of the first to establish the modern type of child guidance clinic. The late Dr. James S. Plant set up the Essex County Juvenile Clinic in 1924, providing one of the first "team approach" clinics in the country. New Jersey at present has a network of mental hygiene clinics under the auspices of the state hospitals, but operated by specially selected outpatient staffs. Clinics of this type<sup>4</sup> are operated in Asbury Park, Atlantic City, Camden, East Orange, Elizabeth, Englewood, Flemington, Franklin, Freehold, Hackensack, Hackettstown, Jersey City, Kearny, Lakewood, Long Branch, Montclair, Newark, New Brunswick, Orange, Passaic, Paterson, Plainfield, Phillipsburg, Red Bank, Riverside, Secaucus, Somerville, Trenton, and Woodbury.

These clinics provide a general community psychiatric outpatient service, as well as service to hospital patients on trial visit.

Clinics are also operated by the outpatient departments of community or city hospitals in Atlantic City, Camden, East Orange, Englewood, Elizabeth, Hackensack, Jersey City, Morristown, Newark, Passaic, Paterson, Plainfield, Somers Point, and Trenton.

Special community clinics, not affiliated with hospitals, are active in East Orange, Montclair, Newark, Paterson, Plainfield, and Princeton. Boards of Education operate child guidance clinics in Newark, Orange, and Jersey City. The Regional Office of the Veterans Administration has a mental hygiene clinic in Newark.

The psychiatric manpower of New Jersey was the subject of a special study by Henry A. Davidson, which appeared in this JOURNAL<sup>5</sup> in 1948. At that time Davidson concluded: "New Jersey, a state with a population of 4½ million, has about 5,000 physicians; of these 262 are doing psychi-

<sup>2</sup> Mettler, Fred. A. Selective Partial Ablation of the Frontal Cortex. New York, Paul B. Hoeber, Inc., 1949.

<sup>3</sup> English, Harrison F. J. Med. Soc. New Jersey, 47: 127, March 1950.

<sup>4</sup> Some of these are operated by county rather than by state hospitals.

<sup>5</sup> Davidson, Henry A. The psychiatric manpower of New Jersey. Am. J. Psychiat., 105: 292, Oct. 1948.



atry, either full-time or part-time, in institutions or in private practice. Of these 262, 75 are board diplomates,<sup>6</sup> and 101 additional doctors (to a total of 176) are members of a recognized psychiatric association. Of the 262 psychiatrists, 112 are in private practice, 93 are employed by state or county hospitals or clinics, and 45 by the Veterans Administration. Psychiatrists are available for private consultation in every county of the state except the 4 smallest,<sup>7</sup> and each of these is adjacent to a county in which privately practicing psychiatrists have offices. Private psychiatrists are available at a ratio of 29,000 persons per practitioner, which is the average, though not the ideal figure." Although no survey has been made since Davidson reported this study, very few psychiatrists have left the state in the last 4 years,<sup>8</sup> and several new physicians have entered the specialty. In broad outlines, the figures reported in this survey are valid today.

No place in New Jersey is more than 2 hours' drive from New York City or Philadelphia. As a result, the state is a favorite place for private mental institutions, many of which are inspected and chartered as hospitals. There are also several special schools for retarded, spastic, or emotionally disturbed children in various parts of New Jersey.

The state has long been active in the general field of rehabilitation. Its Workmen's Compensation Bureau had one of the earliest general rehabilitation programs in the country. The Kessler Institute in West Orange (near Newark) is recognized as a unique institution for the rehabilitation and training of patients with all sorts of long-term disabilities. It has been the site of several national, and one international, conference on the subject.

The major instrument for citizen participation in mental health activities has been the New Jersey Welfare Council, a 50-year-old organization that provides both forums for discussion and mass support for action

in the general welfare field. The Council has always had a strong mental hygiene orientation and was godfather to the more recently organized State Mental Health Association.

In addition to the latter organization, there are local or county mental hygiene societies in Plainfield, Paterson, Atlantic City, and several other areas. New Jersey was the first state in the country to have a Parents Group for Retarded Children.

New Jersey is the most populous state in the union without a medical school. The Legislature has appointed a Commission that has recommended the establishment of such a school. The Commission is now in the process of selecting a site. In the absence of a school, the obligation of furnishing extramural graduate training in psychiatry has fallen largely on the New Jersey Neuropsychiatric Association. For intramural training, psychiatric residencies are accredited at the Veterans Administration Hospital (Lyons), at the State Hospital in Trenton, and at the Essex County (Overbrook) Hospital in Cedar Grove.

The New Jersey Neuropsychiatric Association was established in 1935. It has about 200 members and holds 5 or 6 scientific sessions a year. Since its founding, the Presidents of this Association have been as follows: Drs. Christopher Beling, Ambrose Dowd, Lawrence M. Collins, Joseph G. Sutton, Lewis H. Loeser, Theodore R. Robie, J. Berkeley Gordon, Henry A. Davidson, Charles Englander, and Crawford N. Baganz. Dr. David J. Flicker is the current president, and Dr. Archie Crandell is the President-elect.

The Association has sponsored training courses at various levels throughout its 17 years. It has organized and operated advanced courses, seminars for general practitioners, refresher courses, courses in basic neurology, neuro-anatomy, neuropathology and neurophysiology, and public educational programs. Some of these programs have been presented in collaboration with Rutgers University. Faculties for the courses have been recruited partly from the Association's own membership and partly from medical schools in Philadelphia and New York. The

<sup>6</sup> The number today is about 105.

<sup>7</sup> New Jersey has 21 counties.

<sup>8</sup> Davidson himself, however, was one of them.

New Jersey Neuropsychiatric Association is an affiliate society of The American Psychiatric Association.

Three past-presidents of The American Psychiatric Association were New Jersey residents: H. A. Buttolph (1886); Samuel W. Hamilton (1946); and George S. Stevenson (1949). The second secretary of The American Psychiatric Association, Dr. H. A. Buttolph, served in that capacity from

1852 to 1854. He was a resident of Short Hills, New Jersey.

This year marks the fourth time that New Jersey has played host to The American Psychiatric Association. Previous meetings at Atlantic City were in 1909, 1912, and 1924. Atlantic City, in fact, is always a sort of home town for convention-going physicians in all specialties.

Welcome Home!

## CORRESPONDENCE

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### SCHIZOPHRENIFORM PSYCHOSES

*Editor, AMERICAN JOURNAL OF PSYCHIATRY:*

SIR: In my monograph entitled "Oneriphenia—The Confusional State" published by The University of Illinois Press, Urbana: 1950, on page 3 there is the following statement: "My terms 'symptomatic schizophrenia' (1937) and 'schizoform psychosis' (1938) emerge in Langfeldt's book as "Schizophreniform states" (1939).

In the bibliography of my monograph I gave as reference: Langfeldt, G., The schizophreniform states. London: Oxford University Press, 1939.

I have been reminded by Professor G. Langfeldt, M.D., of the Psychiatric Clinic of the University of Oslo, Norway, that he conceived and published the term "schizo-

phreniform psychoses" in 1937, a year before my term of "schizoform psychoses" in 1938. Dr. Langfeldt called my attention to the fact that in his book "The Prognosis in Schizophrenia and the Factors Influencing the Course of the Disease," Oxford University Press, London, 1937, he had already proposed the term "Schizophreniform Psychoses" and thus the statement in my monograph quoted above is erroneous.

I believe for the sake of scientific accuracy, and to convey proper information to those who are interested in scientific research, the above facts should be published. I do not like to be even an unwitting perpetrator of an error.

L. J. MEDUNA, M.D.,  
Chicago, Ill.

## THE PRESIDENT'S PAGE

### CLINICAL PSYCHOLOGY

The members of the several Affiliate Societies and District Branches who have been conferring with clinical psychologists regarding problems related to certification and licensure have assumed a responsibility of central importance for the future development of clinical psychology and the medical care of the mentally ill. It is a responsibility that every organized group of psychiatrists will need to assume if the present standards for the practice of medicine are to be maintained.

The Council has approved the Joint Report of the Committees on Clinical Psychology and Legal Aspects of Psychiatry and has authorized the Committee on Clinical Psychology to meet with the parallel committee of The American Psychological Association. The Joint Report of the Committees has included careful consideration of the recommendations of the Committee on the Licensure or Certification of Clinical Psychologists of the Section on Nervous and Mental Diseases of the American Medical Association.

The attention of the members is directed to the following extracts from the Joint Report of the Association's two committees: "The American Psychiatric Association fully supports the desirability of designating by legal certification those who, by education and experience, should have the privilege to be known as qualified psychologists.

"The Association emphasizes that when

clinical psychologists work with illness, whether such illness be manifested in physical or psychological symptoms or signs, it is essential that they work under the continuing direction of a licensed physician who is properly qualified to assume responsibility for the particular patient involved. In general, the physicians best qualified for this direction are psychiatrists.

"The Association does not believe that the licensing of psychologists is consistent with sound public policy.

"The Association, being aware of the importance of working toward better relations between psychiatry and psychology, urges its members to cooperate to bring about such advance. We recognize that the professional services of both psychologists and psychiatrists are made more effective when they function together to achieve a common purpose. It is particularly important that training programs in clinical psychology be strengthened, to enable psychologists to receive that type of training which can be given in medical settings to bring about better coordination between these two professions."

These issues in the field of clinical psychology are issues that involve every member of the Association who is seriously concerned with the care of the sick. They are medical problems for which medical specialists in the field of psychiatry need to assume primary responsibility.

LEO H. BARTEMEIER, M.D.

## COMMENT

### THE PROBLEM OF DRUG ADDICTION

At regular intervals the newspapers break forth into print announcing a wave of sex crimes or drug addiction. The public is stirred up, investigations are made, after which a few laws are passed, usually of a more restrictive nature and with greater punishment for violations. Society then settles back comfortably until the next outbreak of newspaper publicity.

Recently there has been a more serious attempt to do something about the problem of sex crimes and a number of states have set up commissions to study the whole problem, some states providing funds for this purpose. California made an initial appropriation of \$100,000 a little over a year ago for a long-time survey and research. The calling in of competent scientific research personnel to work on such a problem is an encouraging sign.

To some extent the same thing has occurred with regard to alcohol addiction. A number of states appropriated considerable sums for setting up research and treatment centers. Society is no longer satisfied to treat the alcoholic with the punitive methods of the past. People are beginning to think of the alcoholic as a sick individual, and a good deal of work is being done toward solving this problem.

Toward other drug addictions society in general retains the same old attitude of horror and wishes to employ punitive methods to the greatest extent possible. At present, the newspapers and magazines are filled with a series of articles dealing particularly with marihuana and heroin. Unfortunately, a large number of these articles represent the older point of view about drug addiction, and many of them are not factual. The harmful effects of drug addiction are usually exaggerated and a great deal of misinformation is being given out.

The psychiatrist has to deal frequently with these problems and is often called upon to give a factual statement concerning this very real and important problem. It is important, therefore, that we as psychiatrists be well informed on this subject and able to give the public a correct statement as to the

nature of drug addiction, its effect on individuals, and the best way of dealing with the whole situation.

It is of interest that the *Military Surgeon* (Official Publication, Association Military Surgeons of the United States), in the issue for September 1951, published an editorial entitled "A Recurring Bogie." In this editorial exception is taken to a discussion on the editorial page of the *Washington Post* of June 24, entitled "More About Marijuana." The *Military Surgeon's* editorial states, "The height of this misinformation is contained in the statement that 'in almost all cases the marijuana habit is accompanied by the slow but progressive mental and moral deterioration of the victim,' and in the quoted opinion that it is likely to end in imbecility or dementia."

There are a few well-established facts that should be emphasized, but which do not commonly appear in the popular articles. The first point is that the prolonged use of such drugs as morphine, heroin, cocaine, marihuana, etc., have comparatively little effect on the physical health of the individual. The harmful moral effects are not due to the physiological effect of the drug primarily, but are due to what Adolf Meyer speaks of as "habit deterioration." The individual, getting his satisfactions from a chemical narcotic or stimulant, associating with poor companions, no longer working steadily, may suffer a serious deterioration in character as a result of these factors, and not as a result of the physiological effect of these drugs.

It is commonly held that these drugs are a cause of crimes of various sorts, particularly crimes of violence and sex crimes. Lawrence Kolb has dealt with this point very adequately. Kolb points out that the effect of most narcotic drugs is to decrease the aggressive impulses of the individual so that he is less likely to commit crimes of violence. An addict becomes more a petty thief and less a murderer. When, however, his cravings for morphine, heroin, or cocaine are not satisfied, he may resort to crimes of violence in order to secure the drug. This differentiation should always be kept in mind.



The marihuana addict has no physiological craving and the use of marihuana does not lead to a true addiction, in the sense that the use of morphine, heroin, or cocaine does. Marihuana can be withdrawn without any physiological symptoms. Bromberg's study of all prisoners passing through the Court of General Sessions, in the Borough of Manhattan, for a series of 5 years, showed that not a single serious crime of violence during that period was due to marihuana.

Here again the psychiatrist might point out that a person charged with a serious crime, and with clear evidence that he has committed such a crime, may resort to the excuse that he was under the effect of alcohol or some narcotic drug, or that he was suffering from a mental disorder so that he was not responsible for what he did. It is interesting how law enforcement officials, and occasionally even psychiatrists, naively accept the statement of a person caught committing a crime of violence that he was under the effect of a certain drug at that time. No proof seems to be required, and we are glibly given a whole series of cases that are said to be due to the result of smoking marihuana, or taking cocaine, heroin, or morphine. In fact, one gets the impression that our law enforcement agencies wish to believe these stories, and feel that they are helpful in backing up their campaign against the use of these drugs.

Reichard, in *Federal Probation* for October—December 1946, in an article entitled "Some Myths About Marihuana," presents material with which every psychiatrist should be familiar. One of the most interesting bits in this article is his exploding the ancient myth with regard to the Assassins, a sect with strongholds in Persia and Syria during the 11th, 12th, and 13th centuries. The story is that "The Old Man of the Mountains" would give hashish (marihuana) to those who carried out murders under his orders. The persons using hashish were supposed to have highly enjoyable sexual hallucinations. The facts are, as Reichard points out, that young men recruited to this organization were rendered unconscious by opium, carried to a garden where they enjoyed the company of beautiful and cooperative young women, and then after a few days were again put under opium, and when they regained consciousness

were told they had been in Paradise, and that this would be their eternal reward if they carried out their master's desires. It is well to note that these people did not have any actual sexual hallucinations and did not even receive marihuana.

It seems unpopular to disprove all these interesting myths and there seems to be a whole group who become infuriated if one asserts that marihuana does not make sex maniacs out of everybody partaking of it. Lawrence Kolb points out that the effect of one marihuana cigarette is perhaps equal to that of about two cocktails, and that alcohol is an infinitely more serious cause of crimes of violence and sex crimes than is marihuana. Statements such as this are likewise attacked by those who seem to feel some need to exaggerate the harmful effects of these drugs. We can say, therefore, with certainty, that alcohol causes infinitely more murders, rapes, and crimes of violence, than do morphine, heroin, cocaine, marihuana, and all other drugs combined.

All of this is not published in defense of various drugs. It is a plea that we be familiar with the facts, and that we as psychiatrists see that the public is correctly informed. All the drugs mentioned are definitely harmful and society is entitled to pass stringent laws regarding their sale and use. It seems that the sale of these drugs is closely linked up with a highly organized criminal syndicate, and an increase in the penalties for those trafficking in these drugs is highly desirable. Psychiatry should support such measures. California has even gone so far as to pass laws under which drug peddlers, under certain conditions, may be sentenced for life. This may seem a drastic way of dealing with the problem, but radical measures seem the only cure for dealing with a problem of this sort.

Let us not confuse the highly organized group of criminals who are selling these drugs with those who unfortunately have developed a habit of using them. Treatment is indicated for the user of drugs. The therapeutic approach is the proper one for those using such drugs as morphine, heroin, cocaine and marihuana. Punitive measures of an extreme degree seem necessary at this point as a way of dealing with the highly organized criminal group selling the drugs. K. M. B.

## NEWS AND NOTES

**LEADERSHIP IN LOCAL COMMUNITIES.**—At the Fourth International Congress of Psychiatry in Mexico City the study group on Leadership and Authority in Local Communities agreed that the San Francisco Mental Hygiene Clinic report by Richard Sears, "Leadership among Patients in Group Therapy," be used as a basis for local studies, from which conclusions may be presented at the interim meeting of the World Federation for Mental Health in August 1952 in Brussels. Suggested topics of further study are as follows:

1. Economic aspects of leadership (by definition: the greatest advantage for the least effort).

2. Dynamics of leadership: how does leadership influence group goals and vice versa?

3. Structural aspects: anthropological concepts; group tests indicating patterns of leadership in relation to group patterns.

- (a) Group attitudes in relation to leadership; is there a group attitude? If so, what is the effect of ethnocentrism, prejudice, authoritarianism, on leadership?

4. Why and how does leadership emerge?

If those interested will send to Dr. Donald A. Shaskan (work chairman of the interim committee) at the Mental Hygiene Clinic, VA, 49-4th St., San Francisco 3, Calif., the results of related studies and indicate the subject on which they wish to work, reports can be exchanged throughout the committee at frequent intervals.

**ALFRED KORZYBSKI LECTURES.**—The first annual series of Alfred Korzybski Lectures took place March 1 and 5, 1952, in the Waldorf Astoria, New York. The Lectures are sponsored by the Institute of General Semantics to aid the publication fund for Alfred Korzybski's collected papers. Speakers on this year's program were William Vogt, author of "Road to Survival," etc., and director of the Planned Parenthood Federation of America, and Professor Ashley Montagu of Rutgers University, consultant to UNESCO

and author of "On Being Human," etc. Receptions were held after the lectures.

**WORK CONFERENCE IN MENTAL HEALTH RESEARCH.**—Another in a series of conferences sponsored by the National Institute of Mental Health, and under the direction of the National Training Laboratory in Group Development, will take place May 9-11, prior to the annual meeting of the American Psychiatric Association. The conference will be led by Dr. Jacob Finesinger, Dr. Eugene Ferris, and Dr. David Shakow. Highlights of the conference will be discussed at a dinner meeting on May 13 during the convention.

The general objective of these conferences, as stated by the Advisory Committee, is "To stimulate research in mental health through the collaborative study of how the concepts and methods of relevant disciplines may be better understood and used." The Advisory Committee consists of the following members: Ronald Lippitt, chairman; Jacob Finesinger (representative for psychiatry); Harold G. Wolff (neurology); David Shakow (psychology); Margaret Mead (anthropology); William Fielding Ogburn (sociology).

Previous conferences have been held in conjunction with the meetings of the American Anthropological Association and the American Orthopsychiatric Association.

**DR. BRACELAND HONORED.**—Leaders in American psychiatry were among the more than 350 men and women who attended a dinner on January 31, 1952, at the Hartford Club, Hartford, Conn., in honor of Dr. Francis J. Braceland. Sponsored by the Consulting Staff, the Courtesy Staff, and the Board of Directors of the Institute of Living, the dinner gave Connecticut doctors an opportunity to welcome Dr. Braceland to his new position as Psychiatrist-in-Chief of the Institute. Dr. Braceland is also president of the American Board of Psychiatry and Neurology.

Toastmaster at the dinner was Dr. Creighton Barker, executive secretary of the Connecticut State Medical Society. Distinguished guests included Dr. Leo Bartemeier, president of the American Psychiatric Association; Dr. Houston Merritt, president of the Association for Research in Nervous and Mental Disease; Dr. S. Bernard Wortis, president of the American Neurological Association; Dr. Daniel Blain, medical director of the American Psychiatric Association; Dr. Edward Whalen, president-elect of the Connecticut State Medical Society; presidents of the medical staffs of the four general hospitals in Hartford.

**FUNDS FOR THIRD INTERNATIONAL CONGRESS OF ELECTROENCEPHALOGRAPHY AND CLINICAL NEUROPHYSIOLOGY.**—The Congress committee for this Third International Congress, which will take place in Boston August 1953, is attempting to raise a sum of \$20,000 for the Congress. Approximately 10% of this amount will be needed for operating expenses but the remainder is to be allocated as grants-in-aid to those delegates from abroad who could under no circumstances attend on their own resources. Support is expected from various drug houses and professional societies. It is hoped that individuals intending to register will become sustaining or supporting members by including a gift in their registration fee and by registering in advance. Interested persons should get in touch with the secretary general, Dr. Robert S. Schwab, Massachusetts General Hospital, Boston 14, Mass.

The Congress is sponsored by the International Federation of Societies for Electroencephalography and Clinical Neurophysiology, of which the president is Dr. Herbert H. Jasper. Dr. Alexander Forbes is president of the Congress.

**TESTIMONIAL DINNER TENDERED DR. OBERNDORF.**—A testimonial dinner in honor of Dr. Clarence P. Oberndorf was given on February 15, 1952, the eve of his 70th birthday, at the Waldorf Astoria Hotel, New York City. The dinner, attended by 350 guests, was arranged by a group of Dr. Oberndorf's close friends under the chair-

manship of Drs. Dudley Schoenfeld and Sandor Lorand. Prominent among those who gathered were many leaders in the psychiatric and psychoanalytic fields, co-workers of Dr. Oberndorf in his varied psychiatric and community activities, and many other friends including alumni of his college.

The spirit of celebration and appreciation for the guest of honor was heartily expressed by Dr. Ralph M. Kaufman, who acted as Toastmaster, and the speakers who included Dr. Leo Bartemeier, Dr. Bernard Glueck, and Mr. I. Howard Lehman.

The early pioneering work of Dr. Oberndorf in helping to introduce psychoanalysis to the United States was recalled by Dr. Bartemeier. Continuing the appraisal of the guest of honor's work, Dr. Glueck stressed his sense of responsibility as contributor and leader in psychiatry and psychoanalysis. Dr. Oberndorf's contribution to the community, especially in the field of caring for deprived children, was eloquently presented by Mr. Lehman, former President of the Jewish Child Care Association of New York. Dr. Marion E. Kenworthy graciously gave the toast of the evening.

Closing the program, Dr. Oberndorf, in his characteristic fashion, utilized illuminating stories to portray his personal philosophy of psychiatry and psychotherapy, emphasizing the limitations as well as the accomplishments in those fields.

Two specially bound leather editions of Dr. Oberndorf's books, "The Psychiatric Novels of Oliver Wendell Holmes" and "Which Way Out," were presented to him as a token of the deep appreciation of all those present at the dinner.

**SECOND NATIONAL PSYCHIATRIC AIDE PROGRAMS WORKSHOP.**—This workshop was convened by the National Association for Mental Health and the American Psychiatric Association, at Manteno, Ill., State Hospital, January 11-13, 1952. The group was composed of nearly the same individuals who attended the first workshop in Peoria, Ill. Many disciplines were represented (including the American Nursing Association) and the two days of discussion touched on many aspects. Interim committees were formed to consider various problems before the next

meeting takes place. The areas covered are as follows: recruitment and selection, teaching contents, teaching methods, aide utilization, practical problems of licensure and relationship to other professions, etc., and historical development. Paul Harris of the National Association for Mental Health will serve as coordinator of the interim committees, which are to send complete reports to him before the next meeting. This is planned to be held in connection with the next Mental Hospital Institute. Dr. Juul C. Nielsen was official delegate of the American Psychiatric Association to this second workshop.

**NEUROLOGIA, NEUROCHIRURGIA I PSYCHIATRIA POLSKA.**—This new review published in Warsaw appeared in 1951 as successor to *Neurologia* and *Rocznik Psychiatriczny*, and the first 3 issues have been received. The title indicates a wide range of topics but the great majority of the contributions in these 3 issues deal with neurological topics. The initial article of the first issue, "The Importance of Pawlov's Science in Clinical Neurology," by E. Herman stresses the central position occupied by Pavlov in Soviet biology. An article on psychosurgery by M. Bornsztajn concludes that the procedure is "scientifically unfounded, based on mechanistic considerations, giving no positive therapeutical effect and impoverishing the personality of the sick. Leucotomy has no theoretical scientific value in psychiatry and should be abandoned."

The editors are as follows: responsible for neurology, Eufemiusz Herman; for psychiatry, Jozef Handelsman; for neurosurgery, Jerzy Chorobski. Many of the articles have summaries in English as well as Polish and Russian.

**SOCIAL SCIENCE RESEARCH.**—The External Research Staff, Office of Intelligence Research, Department of State, recently initiated a project for cataloging recent and current nongovernment social science research on countries and areas outside the United States and its territories. This is a cooperative project coordinated by the External Research Staff and participated in by university staffs, faculty, and graduate

students. The results are available to all scholars who feel that the assembled information will assist them in their research.

The catalog as of January 1952 consists of 13 lists of research being carried on in various topics that have to do with various world areas. List No. 11 is concerned with research on international affairs generally. Supplements to the lists will be issued regularly.

All scholars, including graduate students, are invited by the Staff to contribute to the catalog, and are invited to benefit by the information contained in it. A list on any given subject may be obtained from the Chief, External Research Staff, Room 602, State Annex No. 1, Department of State, Washington 25, D. C.

**ITALIAN PSYCHIATRIC ASSOCIATION.**—Drs. Bernard L. Pacella and Remo R. Cerulli have kindly submitted the following summary of the Proceedings of the 25th meeting of the Italian Psychiatric Association at Taormina, Sicily, September 23 to October 3, 1951, under the leadership of Professor Domenico Pisani of the University of Messina.

The scientific sessions were divided into 3 major categories of discussion: psychosurgery, modern techniques for the study of the psychopathology of the adult and the child, and narcoanalysis. Following the scientific sessions, various business and policy meetings were held, in which discussions included the relationship of psychiatry to psychology, and legal aspects of psychiatric practice.

In the meetings devoted to psychosurgery, under the chairmanship of both Professor Zolla and Professor Bonfiglia, the various surgical techniques, theories, indications for surgery, and clinical results were taken up in some detail. The essential substance of the discussions largely followed the material already presented in the American literature. It is of interest to refer to the presentation by Fiamberti, who mentioned the relatively few cases of psychosurgery in Italy (approximately 530), in contrast to the many thousands performed in America, attributing their difference, in large part, to the high cost of surgery and postoperative care, and

the lack of surgical equipment and of experienced personnel.

The various psychological techniques for the study of the psychopathology of the adult and the child were reviewed and included those commonly employed in America, with special emphasis paid to the Rorschach Test. References were made to "intellectual efficiency tests" such as the Wechsler-Bellevue and vocabulary and performance tests (Goldstein, Porteus, Rubin, etc.).

The section on narcoanalysis dealt largely with its historical aspects, nomenclature, techniques, indications for use, and theories regarding the mode of action of narcoanalysis. Intravenous sodium amytal or sodium pentothal was employed, and administered not only to psychoneurotics but to many groups of psychotic and psychopathic patients. Some favorable results were reported in early schizophrenics and relatively acute psychotic states, particularly the acute delirium of paranoid schizophrenia. Studies were also undertaken in the more chronic schizophrenic patients, the depressive psychoses, the chronic alcoholic psychoses, epileptic psychoses, and the delinquents, with variable and not very favorable results on the whole. Considerable attention was paid to the medicolegal aspects and uses of narcoanalysis, with considerable difference of opinion expressed.

**RESEARCH IN SEXUAL DEVIATION.**—Now available is a report of the State Psychiatric Research Clinic, Detroit, Mich., which was set up as a special facility of the State Department of Mental Health and operated

from January through June 1950. The report is titled "Crucial Issues in the Treatment and Control of Sexual Deviation in the Community." Dr. H. Warren Dunham, author of the report, was research director of the Clinic and is professor of sociology at Wayne University. The report is published by the State Department of Mental Health, Lansing, Michigan.

**ANNUAL MEETING, AMERICAN EEG SOCIETY.**—The sixth annual meeting of the American Electroencephalographic Society will be held at the Hotel Claridge, Atlantic City, N. J., May 10 and 11. The scientific meetings and subscription dinner will take place on the first day, and on May 11 there will be a symposium on the relationship of the electroencephalogram to psychiatry. Dr. Hudson Hoagland is chairman of the symposium, and Dr. Denis Hill of the Maudsley Hospital, London, England, will participate as a guest of the Society.

There will also be scientific exhibits. Dr. R. Knott, Psychopathic Hospital, Iowa City, Iowa, is program committee chairman. Secretary of the Society is Dr. John A. Abbott, Massachusetts General Hospital, Boston.

**NORTH CAROLINA NEUROPSYCHIATRIC ASSOCIATION.**—Officers of this Association for 1952 are as follows: president, Dr. Robert L. Garrard; vice-president, Dr. E. Newton Pleasants; secretary, Dr. R. Charman Carroll; treasurer, Dr. Vernon Kinross-Wright; president-elect, Dr. Richard L. Masland.

The knowledge which men call certainty I deem the faintest dawn of thought.  
What the wild call revelation I deem drunken madness.

FAIZI

(Persian poet, 10th century).



## BOOK REVIEWS

SOVIET PSYCHIATRY. By *Joseph Wortis, M.D.*  
(Baltimore: Williams & Wilkins, 1950. Price: \$5.00.)

To review a book on a highly controversial subject, as well as to write such a book, is a difficult task; for the flames of prejudice feed not only on every deviation from the truth, but also on even the truth itself when this is unwelcome. However, the presentation of such controversial material is nonetheless important. For the reader who approaches this book in a spirit to learn, there should be no insuperable difficulty, provided (1) he lets his critical judgment overcome any emotional bias (pro or con) toward the subject matter, and (2) he understands the point of view from which this material is presented. First let us examine the mood of the book, which is clearly stated by the publisher in the introduction, and also by the author. Dr. Wortis, well known in psychiatric circles, lets us know at once his emotional bias:

"This is a study of Soviet psychiatry approached in a spirit of sympathetic interest; the Soviet scientists are credited here with an earnest regard for human welfare, and their trials, tribulations, uncertainties, reversals and victories are on the whole credited with worthy aims. I do not, however, agree with all the things that Soviet psychiatrists say, and they are indeed not always in agreement with each other."

The book represents almost altogether the officially published point of view of Soviet writers and sympathetic Russian statements concerning Soviet psychiatry abstracted, digested, commented upon, and organized into a consistent treatise by the author. For this task, though Dr. Wortis did not go to Russia, he has familiarized himself with the Russian literature, having, as he states in the preface, drawn from 7,000 abstracted items. Complete references are given on the respective pages.

The subject matter clusters especially about several topics: the concepts of Pavlov as now interpreted in Russia, and of the Soviet controversial points of view especially toward psychoanalysis, the Soviet concept of psychiatry as a sociological aspect of Marxism, the achievements of Soviet psychiatry, including methods of psychotherapy, and especially the relation of psychiatry to the social structure of the State.

The present tendency in Russia is to make Pavlovian physiology the main basis for psychiatry. Certain "Western" ideas are given vituperative consideration, often for no apparent better reason than that they are considered "bourgeois democratic" or "capitalistic." It might be mentioned that a Russian politician is especially adept at branding certain ideas as "capitalistic" when it would be difficult for a non-Marxist to detect any political connection. Psychoanalysis comes in for a good

deal of attention, beginning with the attempt to combine it with Marxist theory to its recent complete rejection by the Soviets. Though some of the Russian psychiatrists have given objective, worth-while evaluations of psychoanalysis, many American readers will take offense at such statements as this:

"The only true evaluation of psychoanalysis is to consider it as a fragment of bourgeois democracy. It is hopeless to try to accept one theory of psychoanalysis and to dispute the other. Those who attempted to inject Marxism into psychoanalysis ended up by being captives of psychoanalysis."

Considerable material is given on the use of lobotomy and other familiar procedures, such as the importance of work. There are also reports on special Russian methods and ideas such as the concepts of Speranskii on neurogenic influences in pathology, of others on drugs and hormones in psychotherapy, of Bogomolets' antireticulocytotoxic serum in schizophrenia, of the "colloidoclastic" shock treatment, of the graded use of sedatives appropriate to the amount of inhibition, of prostigmine for "functional asynapsis" (following head injury), of the sleep treatment of Ivanov-Smolenskiy, of the cerebrospinal injections of Lena Stern. (The reviewer would like to point out that Soviet psychiatry like other Soviet disciplines follows a pattern of logical deduction from theoretical premises with very little examination of the premises). The appendices, being unedited translations of Russian articles on what are for Russians politically controversial concepts (such as the James-Lange theory of emotions) because they have a supposed relation to Marxian dogmas, are valuable for the insight they give us into the Soviet way of thinking.

In the sense of covering all fields and aspects of Soviet psychiatry, the book is a well-balanced treatise. But since it relies heavily on the official published statements of either Russian or other favorable reports of visiting foreigners to the Soviet Union, obviously the book cannot be a balanced appraisal of Russian psychiatry. Nevertheless the volume is an extremely important one for the discriminating reader, mainly because it does give us an opportunity to understand how the present Soviets officially consider psychiatry and how they interpret, politically and sociologically, what we in the "bourgeois, democratic," capitalistic (?) countries are less inclined to consider as political.

And whether or not we agree with the author in his evaluation of Soviet psychiatry, we have to acknowledge that he has made a valuable addition to the history of psychiatry in this most laborious and conscientious review of the enormous literature on the subject—the more difficult a task because most of the material has been in the Russian language. Furthermore it is presented in a readable

consistent manner, thoroughly documented throughout by a well-trained, competent, and erudite psychiatrist. If the reader recognizes this effort as a somewhat conservative presentation of the official Soviet point of view and of the most favorable sympathetic remarks of foreign visitors to Russia, he will possess a valuable source of Soviet medical literature well translated and abstracted, hardly duplicated in any other English book.

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MATERNAL CARE AND MENTAL HEALTH. By Dr. J. Bowlby. (Geneva: W. H. O., 1951. Price: \$2.00.)

This World Health Organization publication is a study of the needs of homeless children, "children who are orphaned or separated from their families for other reasons and need care in foster homes, institutions or other types of group care." The report is divided into 2 main parts: "Adverse Effects of Maternal Deprivation" and "Prevention of Maternal Deprivation."

As would be expected from the title, the first section is devoted to information from various countries on how children are being cared for away from their own families and reviews of such studies as have been done on the effect this care has on the personality and development of the child. As is so often true in the social welfare field, there is a dearth of research and many of the studies that have been done could be open to criticism and question on the basis of strict statistical method. However, as Dr. Bowlby points out, the similarity of findings from independent workers in widely separated areas tends to give validity to the conclusions reached, even though any one of the studies taken alone might be open to question.

Dr. Bowlby feels the evidence justifies the broad general conclusion that "the prolonged deprivation of the young child of maternal care may have grave and far reaching effects on his character and so, on the whole, his future life." However, within this broad conclusion, there is still much research to be done, much to be learned, before we can know how much deprivation, at what age, children can bear without long-lasting or permanent damage. Three general kinds of deprivation are listed: the child who has never had the opportunity to form an attachment to a mother figure in the first 2 or 3 years; the child who has to bear a time-limited separation; and the child who has been changed frequently from one mother figure to another. It is speculated that the resulting damage to the personality may be reflected in different behavior, depending on the type of deprivation; that the child who has never formed an attachment will be more apt to be an isolated or asocial person, while those deprived in either of the other 2 categories may be more antisocial. There can be no specific age set as the time when deprivation has the most serious consequences but all the studies emphasize the first 4 or 5 years. Another question is how long the deprivation can

continue without such severe damage that an irreversible process has set in and no amount of good mothering can atone for the early loss. Again, certainly no age is set and it would probably differ from child to child, but all the studies suggest that it is a relatively short period, probably not more than 1½ to 2½ years, and some researchers would set it under a year.

The second part of the study follows logically on the findings of the first section. Here, Dr. Bowlby discusses various plans now in practice for caring for children and the degree to which they are meeting or attempting to meet the need of the child for a maternal figure. He feels very strongly that not nearly enough effort is put into keeping children with their families; he mentions the failure to recognize the emotional good even in bad homes, the unwillingness of society, as a whole, to spend money for care of children by their own parents and relatives as compared with the vast sums spent to care for children away from home. Going on to the children who must be separated from their own family groups, the report is emphatic in its denunciation of the institutional setting for the infant and preschool child, emphasizes the importance of early placement for adoption, more stable and long-time boarding care. In general, the report sees the institution as suitable primarily for the school-age child for short periods of separation such as temporary absence of the mother from the home or as a treatment situation for the disturbed child. Dr. Bowlby also reminds us that the sick child who is hospitalized for physical care is subject to the emotional trauma of separation the same as a child separated for other reasons. The discussion of management of the sick child was a particularly interesting chapter and should be thoughtfully read by all pediatricians and pediatric nurses.

Much of the report reflects attitudes common to most experienced workers in child welfare and in that sense does not have any dramatic revelations. However, the report is thought-provoking and challenging and anyone concerned in working with children in whatever capacity, doctor, nurse, teacher or welfare worker, will find it worthy of careful study.

The second section explores the manifold problems in considerable detail and, while it reveals our great lags in this field of child care, it also carries a stimulating and hopeful note. No serious worker could read this section without a critical re-evaluation of his own work and his own program as well as his responsibility for the kind of public interpretation that will bring about different and better care. I found particularly worth while the discussion of "bad" homes, "bad" parents, and neglect-situations. The section on institutions, particularly the treatment institutions, is an excellent discussion and pointed up for me some new concepts. This is a report that I feel should be in the office of every child welfare agency, pediatrician, and child guidance clinic.

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**CHILD DEVELOPMENT.** By *Elizabeth B. Hurlock*. (New York: McGraw-Hill Book Company, 1950. Price: \$4.50.)

For any one person to write a book on child development is a prodigious and brave undertaking. The subject is so extensive that it would require contributions from many areas of approach and study to do full justice to it. The author of this book, a psychologist, has compiled a wealth of information as well as, if not better than, a pediatrician, a psychiatrist, a sociologist, or a representative of other fields could have done. Naturally, this volume is weighted somewhat on the side of the psychologist's approach.

The first chapter gives the keynote in its title, "The History of Child Psychology." Two paragraphs contain the reference to Freud's contributions. Gesell receives recognition but probably not enough, considering all that he has done. The emphasis, as indicated, is on the psychologist's contribution, and it is admitted that this has been tremendously important.

Dr. Hurlock has included some important chapters on prenatal development and on the newborn infant—a comparatively new emphasis, except in the realm of physical development. In these chapters, more of the functional and emotional elements might have been given considerable space. A paragraph on the emotional experiences of the mother is hardly enough for this topic. "If the emotional experiences of the mother influence the developing fetus in any way, it is through the glandular changes which take place in her body during the prenatal period" is certainly open to challenge. Numerous other physiological disturbances, as well as future emotional attitudes, enter the picture at this time.

One chapter of 44 pages is given to the subject of the development of speech, while comparatively scant attention is given to reading, writing, and spelling. In the bibliography and index no reference is made to Dr. Samuel T. Orton or to strephosymbolia. Language disturbances, other than speech, are extremely important in child development.

Although 90 pages have been devoted to emotional and social development, the dynamic factors are somewhat lacking in comparison with the statistical and objective observations of the psychologists.

Several other points of "criticism" could be added to those already given. No doubt pediatricians, psychoanalysts, psychologists, and others will find some points of departure for arguments. As stated before, the subject matter is too extensive for fully accurate scrutiny by one person or by one school of thought. Dr. Hurlock has in this book given a compendium of fact and theory pertaining to child development that is not to be found elsewhere so far as this reviewer knows. It should serve as a reference book for people in many fields of work. The bibliography, covering over 50 pages, is in itself a most valuable contribution.

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**PERSPECTIVES IN NEUROPSYCHIATRY.** Edited by *Derek Richter*. (London, England: H. K. Lewis & Co., Ltd. Price: 15 shillings.)

A part of scientific learning that is much neglected nowadays is a periodic synthesis of facts and intelligent speculation into a coherent whole. An appreciation of this kind may not be tenable as new facts come to light but it performs the useful function of serving as an advance camp from which further forays may be made into the unknown. I like "Perspectives in Neuropsychiatry" if only because a number of people have tried to do this. They have in common that they are interested in some branch of neuropsychiatry and that they have, at some time, been students or associates of Professor Golla, in whose honor the book has been created.

To my mind, as a neurologist, the outstanding contribution is that of Professor LeGros Clark, who has the happy knack of making neuroanatomy an utterly fascinating subject. He ranges over a considerable field but has most to say about the hypothalamus and its connections. He has in mind the fundamental importance of this area in the psychosomatic concept of disease. The part I find the most intriguing is the discussion on the function of the mammillary body. It is not seen in submammalian vertebrates and he suggests it is a mechanism for sidetracking the hippocampal impulses away from the primitive autonomic mechanisms back to the cortex or, as he puts it, "recorticalisation." The inference he draws is that this may be a pathway through which cerebral function can be maintained at a cortical level rather than be disrupted by primitive hypothalamic mechanisms. Anatomy expressed like this can be exciting!

Two other essays deserve special mention: Dr. Russell Brain on the "Concept of the Schema in Neurology and Psychiatry" and Dr. M. A. B. Brazier on "Neural Nets and the Integration of Behaviour." They are pleasingly complementary to one another in that the first from philosophical premises draws neurophysiological conclusions, whilst the latter from neurophysiological data draws philosophical conclusions. Both thoughtfully written, they are most excellent reading.

It is impossible to mention each contribution. Suffice to say that with one or two exceptions they maintain a very high standard. Professor Golla has reason to be proud of his teaching.

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**PSYCHOLOGICAL FACTORS OF PEACE AND WAR.**  
Edited by *T. H. Pear*. (New York: The Philosophical Library, 1950. Price: \$4.75.)

It is heartening to see this example of cooperation among social scientists of different countries on a subject of paramount interest. Seven authors in this symposium come from Britain, one from the United States, and one from Israel. In a brief review not all the essays can be covered, but

certainly psychiatrists will find a majority of them packed with valuable information, hypotheses, and suggestions for research and action. Sociological, anthropological, and psychoanalytic theory and data are considered, as well as matters strictly psychological.

In the leading essay, Dr. Pear concludes that "modern warfare is not due to simple instincts, nor is it inevitable." Through the recent development of methods and channels of communication, he believes that it is possible for a new culture pattern to be built up out of an old one. So a warlike nation can be transformed into a peaceful one, if the right people be in charge!

The director of psychology at Maudsley Hospital, H. J. Eysenck, emphasizes the inadequacy of personnel, organization, and financing in present-day research in social psychology. G. W. Allport of Harvard makes the same point. J. C. Flugel suggests a general approach to international amity through a great coordinated work of reconstruction in which the peoples of the world can join, in a spirit of friendly rivalry, against the common nonhuman natural forces that oppose human progress and welfare. "The same battle can be carried on in the soul of man himself," he continues, "in the understanding and control of those forces which man carries in himself and which make for his own degradation or destruction."

Dr. Allport has many other suggestions for research projects to be carried on cooperatively by social scientists all over the world. Among them is the investigation of procedures at international conferences, a project already begun at the last meeting of the World Federation for Mental Health in Paris, under the auspices of UNESCO.

The psychology of aggressiveness is considered by several authors, including Dr. Hilde Himmelweit. In her opinion, aggression is not necessarily destructive, for a person or nation may be aggressively helpful. Dr. Eysenck believes that aggressive attitudes tend to be general, and that there is no evidence in favor of the "sublimation" theory. Dr. Himmelweit calls attention to a study of subjects who displayed aggression in words and at the same time were less neurotic and more amenable and cooperative in actual behavior than those who were less verbally aggressive. There is a need for more research in the relations between individual aggression in local situations on the one hand, and national aggression in international affairs on the other.

Since we know that during the last war a majority of Germans were destructively aggressive toward other nations, something should have been learned by studying them. H. V. Dicks, senior psychiatrist at the Tavistock Clinic in London, interviewed a large number of German prisoners while he was in the British Army during the recent war. He found that the fanatical Nazis and their closest followers had a significant concentration of the following traits: (1) undue acceptance of paternal authority and leader-worship; (2) rejection of tender relationships except at times for sentimental idealization of the mother; (3) over-

evaluation of masculinity and gang solidarity; (4) reading their own motivations into others, leading to scapegoat seeking and a sense of being surrounded by hostile neighbors; (5) sadism; (6) rejection of Christianity for pseudoreligious beliefs or atheism and (7) reaction with neurotic anxiety to situations where they were not at ease. It is his conclusion that "a desperate economic situation . . . favored the emergence of personality types ready to exploit it, and the type existed in sufficiently large numbers to determine the course of history."

The potential role of women is considered by J. Cohen of Israel. "It is perhaps reasonable to assume," he finds, "that a complete emancipation of women leading to their full participation in communal and world affairs would entail radical changes . . . more likely to work toward peace than toward war."

Reading a book such as this should stimulate the efforts of those of us interested in the application of psychiatric knowledge and theories to international affairs. It should also awaken the interest of those whose knowledge of such matters is as yet slight. We should take the position that war may not be inevitable and that human nature may be changed. We should find opportunities to work with other social scientists on research and on public and private projects to lessen the gap between nations, to expedite diplomatic relations, and to study the dynamics of aggressiveness and dictatorship. Through our official organizations psychiatrists can cooperate with other professional groups (such as the Society for the Psychological Study of Social Issues) to gain these ends, and to promote the exchange of scientific information. As individuals many of us can interest our colleagues in these endeavors by recommending this and similar books to them.

ROBERT A. CLARK, M. D.,

Western Psychiatric Institute and Clinic,  
Pittsburgh, Penna.

A CLASSIFIED BIBLIOGRAPHY OF GERONTOLOGY AND GERIATRICS. By *Nathan W. Shock*. (Stanford, Calif.: Stanford University Press, 1951. Price: \$15.00.)

This is an indexed and catalogued reference book that includes over 18,000 references in 14 languages. They are classified in small subgroups no one of which contains more than 150 items. The major divisions are as follows: gerontology, general orientation; biology of aging; organ systems; geriatrics; psychological process; social and economic aspects; and miscellaneous.

The Bibliography is a companion volume to the author's "Trends in Gerontology," and is published in the interest of physicians, welfare workers, and others who are concerned with old-age problems and feel the need of a comprehensive bibliography of pertinent research. The Forest Park Foundation of Peoria, Ill., created for the purpose of improving the care of the aged, sponsored the publication.

M. V. L.

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The Exhibit Sections of the American Psychiatric Association conventions have always been of interest to the members; therefore, the Committee in charge of exhibits has, this year, more than usually, carefully selected those exhibits which provide for the members the most worthwhile of all that is new and applicable in our particular field of medical practice. You are, therefore, cordially invited to visit the exhibit sections, and we will welcome your comments and suggestions.

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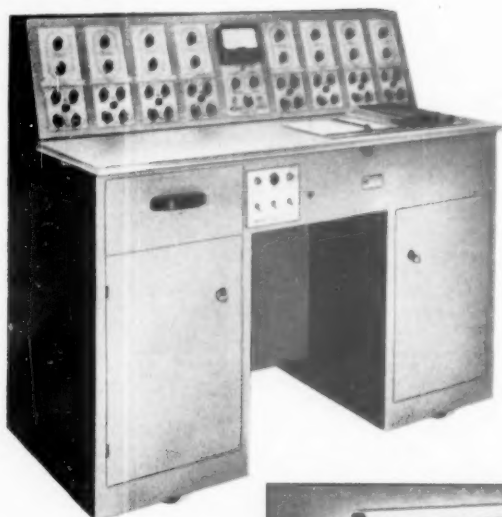
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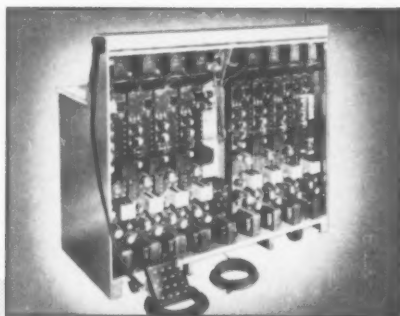
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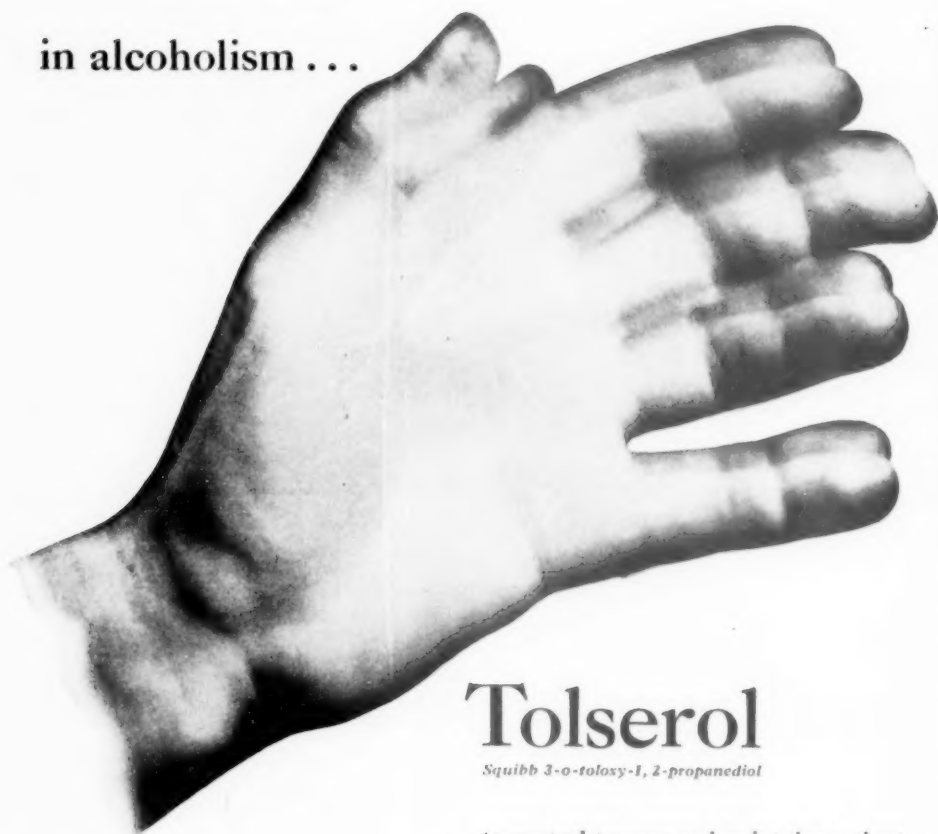
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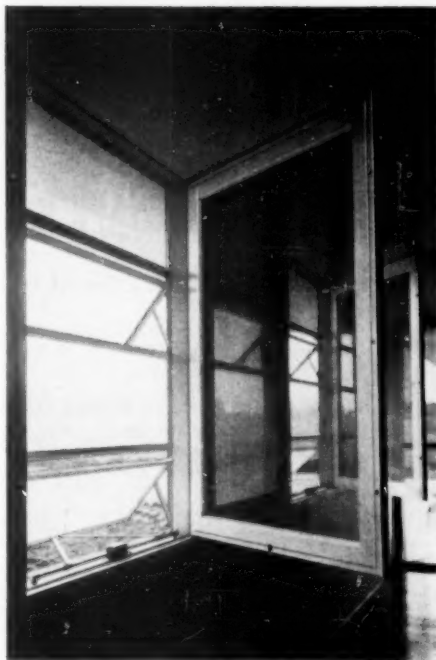
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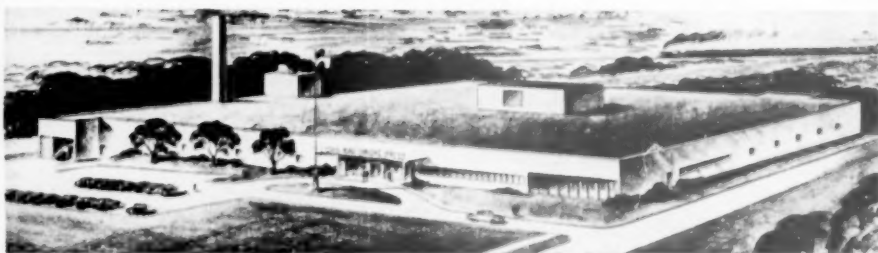
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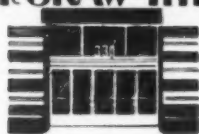
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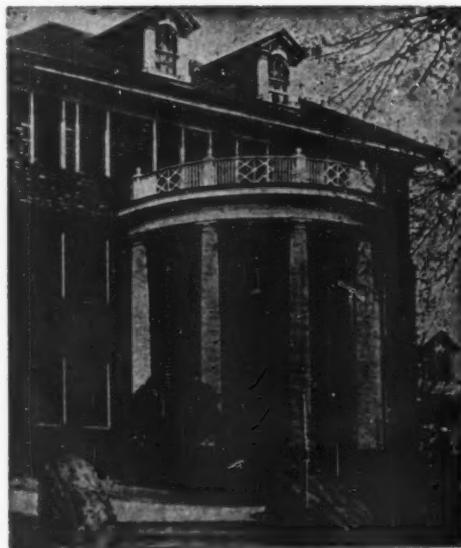
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